CAIPE BULLETIN

No 13: Summer 1997

INTERPROFESSIONAL EDUCATION: WHAT, HOW & WHEN?

Editor: Lonica Vanclay

UK Centre for the Advancement of
Interprofessional Education

About CAIPE

CAIPE, the UK Centre for the Advancement of Interprofessional Education, seeks to promote high quality developments in the practice and research of interprofessional education and training in primary health and social care. This is in order to foster and improve user and carer focused collaborative care.

It was founded in 1987 and became a registered charity in 1991. It is an independent body with some 500 individual and organisational members, comprising advisers, educators, managers, practitioners and researchers from medicine, nursing, social work and professions allied to medicine and social work.

Through its members, CAIPE provides a network for discussion and information exchange by means of conferences and seminars, this bulletin and occasional papers. It promotes research, represents members' views in national and international forums, and works closely with other bodies to promote and develop interprofessional education and practice.

Financial Support

Financial support has recently been received from the Allen Lane Foundation, the David and Frederick Barclay Foundation, Dyers' Company, Girdlers' Company, Lord Ashdown Charitable Settlement, the Department of Health and other donors. The Trustees and Council of the Centre wish to express their gratitude. We are also very grateful to those commissioning CAIPE for project work.

CAIPE Membership and Bulletin.

This Bulletin is produced twice per year and is circulated to all CAIPE's individual members and organisational subscribers. Details of costs and a membership form may be obtained from the office.

Your name and address

Are details of your name, profession and address (including postcode) correct on this envelope? If not please be kind enough to tell us at the address below.

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The copy deadline for the next Bulletin is end September. In addition to contributions for regular features, short articles on the theme of "Interprofessional Education: from projects to mainstream" are welcome. The theme for the following Bulletin (copy deadline end March) is Evaluating Interprofessional Education.

NB Any article not otherwise attributed has been written by Lonica Vanclay

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The Journal of Interprofessional Care

Exchanging experience worldwide, the Journal promotes whole person care through collaboration in education and practice. 1997 issues cover research methodology, user participation and mental health. Issues in 1998 will cover competent to practice, European developments and spiritual and pastoral dimensions of care.

Offers of articles should be addressed to **Professor Hugh Barr**, *Chairman of the Editorial Board, 33 Queen Anne Street, London W1M 0JE. Tel: 0171-255 2880, fax 0171-580 8161.*

Published three times a year, the Journal is available to individual members of CAIPE only at the special price of £32 for 1997, included with a CAIPE membership fee for £52. Enquiries to **Carey McIlvenny**, CAIPE, telephone 0171-278 1083.

Internet Website

CAIPE is to set up a Website by the summer. Full details will be given in the next Bulletin. We would welcome help from two or three volunteers in designing our home page. Please **contact Carey** at the office. Thank you!

International Conference

CAIPE is part of the organising committee for the international, interprofessional conference, "All Together Better Health" presented by the Journal of Interprofessional Care to be held in London from 16th to the 19th July 1997. Participants from over 11 countries have registered. The programme will contain a variety of contributions, including:

- keynote speakers on the views that interprofessional education promotes collaboration and that collaboration improves care;
- other keynote speeches;
- papers on many themes, including teamwork, undergraduate and postgraduate interprofessional education, teaching and learning strategies, evaluation and sustaining collaboration;
- workshops and discussions;
- site visits;
- a humorous theatrical presentation on interprofessional collaboration.

For just £282 this conference provides a cost effective opportunity to join a growing international, interprofessional network and develop a broad perspective on the current issues and challenges of collaborative education and practice. Don't miss it! It is not too late to enroll -

contact **Sue Elcock**, *Profile Productions, Northumberland House, 11 The Pavement, Popes Lane, London W5 4NG.*
Tel 0181-566 1902, fax 0181-579 9258

Evaluating Interprofessional Education

A key conclusion in the report from a national seminar, (see p11), was that we need to be much clearer about the benefits of multiprofessional education. Whilst CAIPE is clearly one of "the passionate advocates" for interprofessional education, we too acknowledge the need for evidence of outcomes to help make the case. Hence, we are undertaking the following activities.

We have prepared **a paper** entitled "Towards Audit and Outcome Evaluation of Interprofessional Education for Collaboration in Primary Health Care". This paper concentrates on the identification of aspects to be considered in the audit (monitoring) and outcome evaluation of a practice based interprofessional education initiative. It is available from CAIPE from July for £4 to CAIPE members and £6.50 to others.

We are planning to undertake **a systematic review of the effectiveness of interprofessional education** with advice from the Cochrane Centre. We have set up a work group, led by Jo Atkins of Oxford Brookes University for the Oxford CAIPE group, to take this forward. Please contact Lonica Vanclay at CAIPE for further details if you are interested. We will be writing to providers of interprofessional education in the near future, asking them to submit any published or unpublished evaluations of their interprofessional education initiatives for the review. We hope you will participate.

The **interprofessional education research support group** meets three times a year. Contact Carey at the CAIPE office for full details.

CAIPE with the Primary Care Education Centre is holding **a workshop** in London on 11th November entitled *Learning and Working Together: Approaching Evaluation.* This is aimed at practising professionals and will include case examples of evaluating interprofessional learning at continuing professional development level and of evaluating the impact on care

of interprofessional practice. Presentations will be followed by small group work on an evaluation task, the information for which will be circulated to participants before the day. For full details and an enrolment form contact the PCEC, West Ealing House, 2 St James Avenue, London W13 9DP Phone 0181-893 0730.

We are collaborating with the University of Liverpool Department of Healthcare Education, the Health and Care Professions Education Forum and the Medical and Dental Education Forum to hold a conference in Liverpool on the 27th and 28th November about whether interprofessional education works. Keynote speakers will outline approaches to evaluating interprofessional education up to registration stage and describe the evidence of its effectiveness available so far. The programme will include small group work to explore strategies for evaluation. The conference has received funding from the NHSE North West and promises to be interesting, informative and enjoyable.

*Contact **Margaret Boaden**, Dept of Healthcare Education, University of Liverpool, 3rd floor, University Clinical Department, Duncan Building, Liverpool L69 3GA on phone 0151-706 4293 for full details and to enrol.*

CAIPE Annual Meeting

In her address at CAIPE's Annual Meeting and Symposium on 7th May, Gill Newton, Head of Education and Workforce Planning at the NHSE, reported on the themes emerging from the professional development consultation (see report p11).

On the core characteristics of the workforce, an ability to really put patients at the centre was crucial. This required more than just good communication skills. Services would need to emphasise health promotion more, and more clinical placements providing experience across health and social care would be needed.

Many commented on student selection and noted a need to reduce emphasis on academic results and for further research on selection.

The importance of training for teachers was stressed, as was the desirability of Lecturer/Practitioner posts and

using existing monies to enable a learning facilitator to be employed in every primary care setting.

Shared learning was considered most appropriate at postqualifying level. Some favoured a common foundation course, others wanted shared modules at undergraduate level. The practical difficulties of developing interprofessional education were recognised.

The need to develop a culture of lifelong learning within organisations, including Trusts, was recognised. Equity of access to learning for all professions would be necessary, and appraisal systems that reflected individual and organisational learning needs would need to be widely used.

Despite some good liaison between regulatory bodies, partnerships between stakeholders need improvement, and the NHSE needs to improve its own communication methods.

Separate funding streams inhibit progress, and need changing.

Small group discussion on key issues arising from this followed.

How do we create an environment for learning? Education and service providers need to recognise the need for and fund appropriate practice based placements as an 'investment' in a future high calibre workforce. 'Hub' and satellite arrangements using Lecturer/Practitioners to motivate staff, facilitate networking and promote interprofessional learning would help.

How do we prepare qualified practitioners and teachers to assist students to develop the core characteristics of a highly trained and skilled workforce? Everyone needs to learn interactive and multiprofessional skills which requires cumulative learning over time and trust. Collaborative projects, learning sets and role modelling will help.

How do we improve partnerships and develop them to include users and carers? Identifying and understanding all relevant stakeholders and acknowledging that each contributes something different is an important first step. Creating umbrella bodies to reduce the number of stakeholders, encouraging educational institutions to collaborate on topic areas and

including medicine within the remit of consortia could help.

Members suggested that CAIPE's priorities for the coming year should be to maintain its independence, improve its funding base and continue its networking and facilitating role. It was suggested that CAIPE clarify the particular skills needed for interprofessional teaching, gather knowledge of techniques that facilitate interprofessional learning and details of facilitators/consultants, develop evaluation tools, link with consortia, spread success stories and work more closely with practitioners as well as organisations.

Reorganisation

CAIPE's Trustees and Executive have agreed that CAIPE should change from a Trust to a charitable company limited by guarantee. Members of the governing Board would be elected by CAIPE members. The Memo and Articles of Association are being drafted with a view to the company being operational from the 1st October. The current Council will become the Board and it is planned that postal elections will be held early in 1998.

A Personal Note

After three and a half very rewarding years at CAIPE as its Director, I will be leaving at the end of July to move on to another post. I have learned much during my time at CAIPE and have enjoyed and valued greatly the opportunity to work with you all. I will be going to a voluntary organisation, Family Welfare Association, where I will be involved with developing family support services in health settings, amongst other things. This means I will become an active member of CAIPE, involved in interprofessional service development. I would like to thank you for your contribution to CAIPE in the time I have been here. I would be delighted if you could join me for a glass of wine or two on Tuesday, 15th July from 5pm - 7pm here at CAIPE. CAIPE is now recruiting a new Director to lead the next development phase. I am sure the new Director will welcome and need your continuing support for CAIPE.

Northern Ireland

CAIPE hopes to hold a meeting and workshop on interprofessional education in Northern Ireland early in 1998, and would be pleased to hear from partners willing to help develop plans for this.

Scotland

A meeting will be planned for 1998.

Wales

A CAIPE meeting about interprofessional education will be held in Wales on 15th October. This will be an interactive, participative event providing an opportunity to meet colleagues, to share information about developments, to begin to identify and discuss issues about the development of interprofessional education that are of mutual concern and to consider possible future activities by CAIPE and others that would support continuing developments in interprofessional education in Wales. CAIPE has been commissioned by the Welsh Office to undertake a consultation exercise to identify the way forward for developing interprofessional education in Wales, and this meeting will be part of various activities which will form part of this project.

England

Issues the education consortia in each region of England will be considering include:

- integrated workforce planning - of both medical, nonmedical and general medical personnel;
- changing workforce needs and how to develop and train staff;
- postbasic education and training - especially teamworking;
- preregistration shared learning - what common elements can be shared to cut costs;
- future needs for new practitioners;
- evidence of the benefits of interprofessional education and practice to support its development.

The REDG (Regional Education and Development Group) is responsible for advising the Regional Office on strategic education and training issues. It enables the views of the service to be put forward to the national NHSE in Quarry House. The REDG also has a role in ensuring that the plans of the consortia fit within national priorities and guidelines. Hence, CAIPE members have been meeting in many areas to consider how to link up with consortia and the REDG, aiming to develop a continuing dialogue with them on interprofessional education developments.

Anglia and Oxford

At the Anglian CAIPE meeting in November, Bryony Lamb explained how Anglia Polytechnic University secured support for their interprofessional education developments, and emphasised the time and persistence needed and the wide range of stakeholders who need to be involved. Issues relating to organisational requirements, funding, adequate time for development, assessment, incorporating a variety of collaborative rather than competitive methods, articulating academic and professional requirements, working with Trusts, involving GPs and balancing service and professional needs all need to be addressed.

In discussion, it was recognised that initiatives were sustained by:

- having a subject and practice focus rather than a qualification or professional award focus;
- maintaining a clear vision about the overall purpose of the initiative;
- having models of successful partnerships;
- establishing a steering or advisory group and a course development and planning group with external members;
- building in evaluation from the outset, perhaps by action research;
- meeting regularly with the NHSE Regional Office;
- networking with colleagues.

Members have circulated details of their activities and interests to facilitate networking, and will meet twice a year. The next meeting will be on **28th October** from 12.30 to 2.30pm in the Ipswich area.

The Oxford CAIPE meeting was held in March. The following activities were identified, during discussion, as useful developments to undertake.

- Developing an outline for a module in collaborative skills, approved by professional bodies, for courses to adapt.
- Undertaking a systematic review of studies of the effectiveness of interprofessional education and collaboration in practice.
- Encouraging joint service commissioning strategies and providing plans to specify implications for professional practice and consider how they could proactively encourage interprofessional practice and education.
- Exploring ways of encouraging practice teams to integrate interprofessional learning into their service provision and continuing education activities.

Members will meet every six months to continue to network and share ideas and resources and progress activities. The next meeting is **14th October** from 12 to 2pm in Oxford. It will include an outline of work undertaken recently on shared competencies in public health to introduce a discussion on the future workforce needed and an outline of theoretical frameworks for clinical supervision to introduce a discussion on possibilities for developing joint practice supervisor support.

A regional seminar was held on 30th April, looking at involving users in interprofessional education and using action research to evaluate interprofessional education. A report of this seminar will be included in the next Bulletin.

Northern and Yorkshire

The CAIPE group holds two lunchtime or halfday seminars per year on topics of mutual interest in the

Newcastle and Teeside areas. Recent topics include domestic violence and the conflict between confidentiality and sharing information with and about people with mental health problems. Plans for further meetings will be finalised in the near future.

The group met with representatives from several of the regional consortia in December and discussions about links are continuing.

*Contacts are **Dr Chris Drinkwater** and **Dr Pauline Pearson** at Department of Primary Health Care, University of Newcastle. Phone 0191-2226000*

North and South Thames

CAIPE's Director has been discussing issues of interprofessional education with the Regional Nurse Director, Director of Postgraduate Medical and Dental Education and the Director of Education and Training. Likely developments in the region will focus on mental health.

There will be a planning meeting at CAIPE on **23rd June** from 1.30 to 4pm for interprofessional education supporters in the two regions to formulate plans for how to link up with the consortia and encourage them to support further developments. Contact Lonica Vanclay at CAIPE if you would like to attend.

CAIPE will hold a seminar on approaches to evaluating interprofessional education and practice on 11th November in partnership with the Primary Care Education Centre. See CAIPE News for full details. This will be a participative, interactive event, building on the seminar held in October entitled Learning Together to Work Together for Primary Care. It aims to help develop a supportive network for interprofessional education enthusiasts in the South East.

South and West

CAIPE has been working closely with the NHSE South and West regional office, which has been funding and developing a programme of interprofessional education projects. Details of the regional office's programme can be found in the section on UK Developments.

CAIPE helped run a seminar in January for funded projects to share information and network with each other, to identify key issues in developing multiprofessional education and their implications for the REDG and commissioners and to generate ideas for dissemination of lessons learned from the programme. Ideas for future action were suggested and are being taken forward by the regional office. CAIPE will continue to support the regional office with this programme.

Trent

CAIPE members met in February, exchanged information about their activities and heard from Norma Brook how Sheffield Hallam University overcame some of the difficulties of developing their integrated interprofessional undergraduate level course. They will meet again on the **7th October** in Rotherham from 1.30pm to 4.00pm.

West Midlands

In partnership with a working party of postgraduate medical educators, established by Dr Roland Spencer-Jones, and Marion Rogerson, the Primary Care Development Officer from the NHS Executive, CAIPE helped run a workshop in early February to explore possibilities for encouraging education in the West Midlands to reflect primary care and community developments, including the need for interprofessional collaboration. The workshop was funded by the NHS Executive West Midlands.

It was agreed that current service provision needs meant changes in professional education were needed, with interprofessional learning essential. Many felt primary care was the best location for interprofessional developments. Some felt it was most appropriate at postqualifying level when professionals are secure in their own role.

Elements contributing to the success of interprofessional developments were identified as:

- focusing on practice tasks where collaboration is necessary;
- collaborating and sharing with other educators and trainers - networking;

- good management and careful organisation;
- ensuring learning builds on and reflects the personal learning needs and situations of participants;
- building on existing interprofessional activities such as audit;
- all stakeholders must be committed and consider the development relevant - this commitment must be maintained;
- having a mix of professionals;
- involving appropriate partners in planning from the outset;
- gaining accreditation;
- developments should link with the educational priorities of the consortia;
- all participants must be equally valued;
- local enthusiasts must drive developments.

It was agreed that interprofessional education in the West Midlands should consist of a wide range of projects, and should be promoted as a continuous process at all educational stages. The interprofessional education should focus on what was in the best interests of patients, reflect the primary care led NHS and aim to develop interprofessional understanding and trust and collaborative skills. It was recognised that developing interprofessional initiatives was a slow process which required the development of a longterm strategic plan, securing agreement from all stakeholders, forging links and taking incremental steps. A sensible timescale which balanced revolutionary and evolutionary approaches was necessary. Evidence of effectiveness should be gathered and national lobbying by bodies such as CAIPE, was needed to ensure that adequate resources are allocated.

Options for future interprofessional developments were identified and plans for going forward will be developed

Conflicting Voices: Acknowledging the Real Political Message on Interprofessional Education

When we seek the reasons for the continuing failure to advance interprofessional education, we concentrate on 'Professional Intransigence', the 'Health Tribes', 'Educational Failures' etc, and so solve the problems by sharing 'best practice'. We ignore the political context within which we work. There is an assumption that the message from our political bosses is clear, unequivocal and pro-interprofessional education. This is a calamitous mistake.

Ann Loxley, in 'Collaboration in Health and Welfare' (see page 37), lists 25 Government Acts and Public Reports about the purpose, mechanics and strategies of collaboration. However, these reports are often political expediency, platitudes of 'the motherhood and apple-pie' variety. Politicians must be judged by their actions, not by their words. These often show a totally opposite picture and demonstrate, that we have yet to win the political arguments for IPE. Unless and until we do, our successes will be both small and transitory. Ministers look for short-term gains, Ministries have narrow definitions and both confound IPE.

In 1971 CCETSW was established and Social Work Education became 'generic', bringing together the various professional groups (tribes) involved in social care in one qualification. A triumph for IPE. It included Probation Officers as well as Local Authority Social Workers. In 1995, probation training was withdrawn for reasons of short-term and political gain despite a Home Office survey showing 89% of Magistrates were 'very' or 'quite' satisfied with the Probation Service and limited support for the change.

The Diploma in Social Work was just 14 months old when it had to be rewritten to meet Government demands. Initial Teacher Training where the National Curriculum has been changed 5 times, and the time

for college teaching is so reduced that on the Post Graduate Certificate in Education, 25 of the 36 weeks of the course are in schools is another populist, anti- intellectual move. This means that opportunities for IPE with others including social workers and health personnel on child protection or drugs is severely limited and made virtually impossible by the Teacher Training Agency who wish to see learning directed at classroom specific topics and in education specific groups.

IPE requires a readiness to work on the long-term issues. It also requires a more holistic and systematic approach. Social Services Departments which offered this are now being broken up into the separate divisions of Children, Adult Services, Mental Health etc which were tried and found wanting by Seebohm in 1968.

The fragmentation of structures causes further complications. When CCETSW reviewed the Diploma in Social Work (Paper 30) it had to get the separate agreement of the DOH (who sponsor CCETSW), the Welsh Office, the DHSS in Northern Ireland, the Scottish Office, the Home Office (for Probation), the Department of Education and the Department of Employment. Seven competing departments with often conflicting agendas, whose record of 'co-operation' includes a mental health initiative in London to re-house homeless, mentally-ill people where none of the 750 housing units have been built because of a dispute between the DOH and the DOE over who should pay. Budgetary concerns and narrow target setting lead to the ever narrower definitions of responsibility and activity, which so confound IPE.

The perpetual changes of the last 5 years have brought exceptional turbulence and insecurity to all in health and social services. Turbulence and insecurity inhibit collaboration. Competition, another barrier to collaboration, is promoted.

Whilst seeking and sharing best practice we must therefore also turn our focus to the political context in which we work. We should seek to influence politicians and alter the structures through which they work.

We should seize this opportunity to encourage Ministers to seek the real and meaningful change IPE offers, to discard the 'quick-fix' as politically contemptible and to seek holistic not narrow approaches. This means opening a determined political dialogue with Ministers and Civil Servants, accepting that our fields of work will always be political and that the only way we can succeed is by acknowledging and influencing the political reality.

We should have a clear agenda of what is required. As Tony Blair said on 2 May, before we could only 'say', but now we can 'do'. We must help the government to 'do' that which will enable IPE.

Professor R Firth, Faculty of Health, Social Work and Education, University of Northumbria, Coach Lane Campus, Newcastle upon Tyne NE7 7XA

Exploration of a Fellowship 1993-1996

Although much has been said and written about the advantages of interprofessional working, most professionals, even those working in close physical proximity, spend much of their time in isolation and do not use opportunities to share problems and learn together. This is reflected in their patterns of education. We seldom see social workers or nurses encouraged to join GP postgraduate education or GPs participating in teaching initiatives arranged by other professions. Most education is arranged by specific professional groups for their own kind and many feel threatened if encouraged to look outside this.

These difficulties are reflected at a strategic level with policies for interagency training being the exception. With few exceptions, there is little enthusiasm among different agencies to collaborate and encourage multidisciplinary participation.

Physical disability, the area of specific concern for my three year part-time Fellowship, has little time spent on it in continuing education. It is often

dealt with in a didactic manner. I found that GPs in particular seldom thought that education specifically targeted at physical disability was relevant or attractive.

Nonetheless, I believe that there is great potential for using the many facets of physical disability as a vehicle for interprofessional education. The need for collaboration between professionals for people with multiple disabilities is very clear. Physical disability is no respecter of the boundaries of age, culture or race. Using the disability model forces people to consider the means by which they communicate and collaborate. It also provides a very powerful forum in which users can have a voice. The main concern for most patients is not the medical details of what has caused their disability but the effect that it has on their everyday lives. They make us move from the minutiae of clinical diagnosis and unachievable cure to consider pragmatic ways of preventing disabilities becoming a handicap.

Many disabled people require and receive services from a wide variety of professionals, private agencies and volunteers, often drawn from different teams with their own values and methods of working. Historically there has been little contact between them and they may be separated by an ideological gulf in their ways of dealing with problems.

For my Fellowship, I needed to develop a strategy to raise the profile of disability in primary care. The most effective way seemed to be by linking the provision of educational activities with opportunities for practices to improve their services for disabled people. This required strategic support and investment, identifying the fault lines in the system where a gentle lever might promote change. Serendipity and being in the right place at the right time played a part.

I developed a range of options. Interventions were planned to meet the varying needs of practices and directed at practice teams and other local professionals with whom they worked. They included opportunities to improve practice access and information and a structured educational programme which allowed practices to decide the level of involvement with which they felt comfortable.

It was not easy to encourage interest and participation. I learned important lessons about the features of effective interprofessional educational interventions.

Activities should contain a minimum of formal presentation.

Activities should appreciate and utilise the power or voice of the user, focusing on the user's perception of the problem, wherever possible, with direct input from disabled people themselves.

Initiatives have to be pitched at different levels and one must not be discouraged by an apparently poor uptake. There will always be a spectrum of responses.

It is important to consider how an educational initiative can be sustained.

Formal external evaluation may not be appropriate as initiatives rely on the active and ongoing participation of the 'research subjects' with self-analysis promoting sustained change.

Progress is frustratingly slow. Organisations need to be stroked and cajoled and one has to accept that meetings are frequently cancelled or postponed. Developing a communications network between like minded people is slow and often occurs by chance.

It is necessary to work at all levels. It is important to accept the unpredictable and take opportunities as they arise.

The development of a local agenda is largely influenced and shaped by the experience, enthusiasm and vision of a number of individuals.

Small and local is beautiful. Although small scale, locally based training is very hard work to organise, it has the greatest potential for producing lasting change in attitudes, behaviour and ultimately quality of service. My successful educational interventions have been small scale activities with a strong element of problem solving involving professionals and users. Change is more likely to be sustained by a series of small bush fires rather than one large conflagration.

Dr Tim Hill, RCGP Prince of Wales Fellow for Physical Disability, Field House, Field Drive, Moele Braces, Shrewsbury SY3 9HJ

Education for Collaboration Fellowship

The RCGP/RCN/DoH Education Fellowship is a unique collaboration between two professional organisations. It arose out of a need to meet the present and future education requirements of nurses and doctors in the context of a move towards an NHS led by primary care.

We work one day a week on the project while retaining practice commitments. Our aim has been to examine the broad issues of interprofessional education and to relate these more clearly to the primary care/general practice setting. Through this process we are working to facilitate the development of relevant shared and interactive learning between general practitioner registrars (trainees) and (specialist) community nurses who are training for primary care. We have, from the outset, adopted an egalitarian approach - equal pay, input, leadership and accountability.

Management of change principles are being used and incorporated into an action research (qualitative) methodology. An attempt to define 'the state of the art' was made through a national survey (England) using a postal questionnaire developed from a similar tool used by CAIPE for their own surveys of interprofessional education activity. In addition, networks have been developed at policy, education and practitioner level and educational structures and funding arrangements were examined.

The survey was made more difficult due to the introduction in 1996 of the new educational programmes for specialist community nursing, which incorporate core curricula and eight possible nurse pathways. This involved all the nursing institutions in a major redesign of their courses and it appears that this was a major factor behind the low response rate by nurse educationalists (47%; 9). There is no national database of vocational schemes for general practice, making it difficult to ensure that our questionnaires were received directly by the course organisers concerned. We suspect that this was one factor behind a low response rate from GP course organisers (40.8%; 73). Nonetheless, it appears that many postal questionnaires are currently

achieving a response rate of this order and it may be time to reevaluate whether practitioners and educationalists in the NHS and higher education have reached saturation point!

The survey revealed some very positive examples of collaborative learning which, in some cases, had been ongoing for over 10 years. We hope to describe and disseminate these to show what is possible. However, the level of negativity, apathy and sometimes antagonism to the possibility of interprofessional learning between nursing and medicine is also a cause for concern. We feel that interprofessional education at this level of training for primary care is unlikely to become normative unless there is fundamental change.

Certainly recent discussion documents relating to the Primary Care Act (i.e. 'Primary Care The Future'; 'A Service with Ambitions'; 'Delivering the Future') have envisaged a team-based approach to service delivery, but to be fulfilled there will need to be further discussion and incentives to produce significant change.

There is reason to be optimistic that a more collaborative approach between education providers themselves and also across the education/service delivery split will deliver these changes (for example, the lecturer/practitioner role). At the moment, it is the enthusiasts within the field and those intent on improving the quality and co-ordination of care, who are leading the way. A possible way forward is through the setting up of 'interprofessional cells' in each locality to develop these approaches and to think creatively about structures and funding.

We would be interested in hearing from any educationalists or practitioners who have experience in this area of education for primary care, or who are thinking of developing such links and would like to discuss this further, or who need to find out who are the 'links' in their own locality or university.

Andy Watts (GP Fellow) & Chris Lenehan (Community Nurse Fellow),
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Developing Partnerships in Mental Health : Health and Social Services Working Together

The recent Green Paper on Mental Health provides an opportunity to revisit models and experiences of working together. It reflects enduring truths about the dilemmas facing mental health services regardless of the politics of the prevailing government. The lessons from enquiries highlight the consequences when systems fail; when working relationships between individuals and agencies are weak or disrupted; and when vulnerable individuals on the fringes of our communities are overlooked. Less heralded, yet far more significant in informing the continuous development of responses, are the daily experiences of the system working, albeit sometimes on a 'good enough' basis.

At a recent conference, organised jointly by CAPITA Training and the Centre for Mental Health Services Development, asking about the images created by the term `Working together' stimulated responses such as riding a tandem, membership of an amateur orchestra, singing in a choir or playing in a week-end cricket team. These images have in common a sense of unifying purpose and familiarity between the participants.

For those working outside the major metropolitan centres, continuity and hence, familiarity, is not hard to achieve. The challenge for those in cities is how to ensure joint working when key people change jobs frequently, as one re-organisation follows another.

This confidence, trust and familiarity which develops between the people who make the system work on a day to day basis is crucial. Local experience has shown that conscious links have to be made at all levels of the organisations involved. The elusive ingredient trust can only be nurtured and sustained if those involved have achieved results together in good and bad times.

Existing models of working together seem to depend upon very detailed procedures eg. child protection. Such arrangements do not just happen however. They have to be built with a sense of purpose and incorporate structures which relate to the way business is done within and between the key agencies.

Our local area includes four local social services authorities and four NHS Trusts and the health authority, probation services and police authority who cover a wider area. Locally determined procedures develop and function within overall policy and strategic frameworks.

Chief Officers meet at programmed dates throughout the year across all the agencies. Locally, Chief Executives and Directors meet individually and jointly with their management teams. The agenda reflects current concerns and prospective topics. At day to day operational level, professionals and care staff are expected to work to joint and/or common protocols. A topic of major current concern being discussed at all levels is the extent and appropriateness of information sharing. Joint documentation of Care Programmes is currently being piloted in one locality. Joint training across a number of activities is a feature. Emphasis is placed on the induction of newcomers into the expected ways of working. And at Chief Officer level, we are not slow in drawing attention to shortcomings in each others' organisations!

There is, though, an illusive element to successful joint working - that extra dimension that makes it hum. Some people are clearly better performers. These are the resource investigators, the people who are never in their offices, who are out building bridges and doing deals. They have demonstrable competencies which ensure, that the transactions are transforming rather than relatively passive exchanges of information, and that they bring benefits to the participants, their team and organisations and fundamentally for patients and service users.

To keep all this going, we have to maintain our faith. There are images which help us understand how we work together and there are models of working together in mental health and elsewhere on which to build. We owe it to those in need to ensure that we create formal processes and structures to enhance the learning and the working together. These things will just not happen through exhortation. You and I have to make a difference.

Mike Lauerman, Director of Social Services, Hartlepool

The National Council for Family Proceedings

The National Council for Family Proceedings, a registered charity, was set up in 1991 to advance the education of all those who are involved in the Family Justice System. It encourages professionals to develop interdisciplinary approaches to family proceedings for the benefit of families.

The Council's activities involve organising conferences, seminars and other events for the dissemination and exchange of ideas and information between different disciplines, promoting the development of principles and standards in cooperative working and training opportunities across professional boundaries, and assisting organisations and Government departments to explore ways and establish projects by which family proceedings can be better co-ordinated.

Of current interest is a project to assist with the arrangements to pilot the information meetings for the Family Law Act 1996. The Council is co-ordinating the introduction of information packs, videos, training materials and guidance for those who will conduct the information meetings. It is setting up a local interdisciplinary forum in each pilot location, which will bring together representatives of all relevant professions to support the pilots.

The Council is a membership organisation. There are two types of membership. Corporate Membership (£117.50 per annum) is reserved for national organisations or bodies working in the field of family justice which support the Council's work. They nominate representatives for the Council of management. Ordinary Membership which has three categories, Organisational (£58.75 per annum), Individual Associate (£25.00 per annum) and Individual Student (£11.75 per annum). Benefits of membership include reduced fees at NCFP events, invitations to bi-annual meetings and free copies of the tri-annual newsletter.

New members are welcome. Contact *Iris Murch (Conference Administrator), National Council for Family Proceedings, Centre for Socio-Legal Studies, University of Bristol, Rodney Lodge, Grange Road, Bristol BS8 4EA Phone 0117-973 1462*

James Lawson, Chief Executive

CONFERENCE REPORTS

'Whose Body Is It Anyway?'

Summary of the Annual Herald Lecture given by Professor Sheila Maclean in Glasgow in September 1996.

Questions of information and its control and dissemination are matters of increasing significance for individuals, as much "private" information is now known to, held by and accessible to professional groups. The technological revolution makes the holding of information ever easier. The whole question of holding, sharing and disseminating information must be considered from a wide perspective. The challenge to all professions is to respect the trust of those about whom information is held, and to respect the wider community affected by that information.

An accepted exception to breaching confidentiality is when information is in the 'public interest'. This is both vague and potentially damaging of the professional/client relationship. If drawn narrowly, it may permit social harm in the shape of threats to individuals or groups. If drawn broadly, it can negate entirely the basis of the professional relationship itself, namely trust. What is being balanced is the need or the claim to know against the commitments which professionals make, individually or indirectly, which encourage the sharing of information. The interests at stake shape and reflect societal and ethical values, not just the practice or custom of one particular profession. Many professional codes are consistent on maintaining the confidentiality of information. This should be an increasing obligation and duty.

The press may well jump with glee on an apparent failure to pass on information or to withhold it. There is a need to demonstrate clearly that one is working to sound professional codes and to consider carefully and thoroughly the basis of their actions and judgements. Nowhere is this more important than in the control and dissemination of information. Older professional groups such as medicine and law have long struggled with these dilemmas and have built up experience which newer professionals may learn from.

In health, recent concerns over confidentiality stem from the acquisition and possible uses of genetic information. Genetic susceptibility may render people ineligible for insurance or employment and may complicate family relationships. Since our genes are not merely ours but are shared with our family, some may feel, for example, a moral obligation to share what would otherwise be the most private of information with others. Private behaviour is also increasingly the subject of scrutiny and a fine line has to be drawn between what is in the public interest and what is interesting to the public.

It is time for a serious and informed public debate about information dissemination and holding. The time is long overdue for this country to accept that privacy is a valuable concept, enhancing liberty. For those responsible for holding sensitive information, privacy draws clear boundaries which both protect the individual and enhance communication. A clear exposition of the principles which underpin privacy laws has the potential to lead to harmonisation of the way professionals and non-professionals alike evaluate when their public duty exceeds the guidelines which form the cornerstone, but not the sole justification, for either professional status or practice. This harmonisation will lead to greater appropriate openness between those who hold the information and will facilitate better individual and community decision making.

Report on the 3rd National Inter-Agency Child Protection Training Symposium

In recognition of the challenges facing inter-agency child protection training from organisational and political changes, the theme of this year's annual Symposium was "Anchoring ACPC (Area Child Protection Committee) Training in a Shifting World". Helen Armstrong opened the event with an analysis of current pressures for change and what these might mean for inter-

agency training. "Child Protection: Messages from Research" called for "new alliances, new ways of working and new skills and knowledge", which would apply differentially to different agencies and disciplines. Trainers need to maintain a dialogue with those leading policy change and with practice.

Workshop sessions allowed those involved in inter-agency training to assess the relevance and implications of these changes for their own role, alliances and training. Sara Glennie provided a framework for enabling participants to remain centred and effective in the midst of change. She emphasised the importance of valuing the achievements that had been made in inter-agency training; the increasing consensus about objectives, greater role clarity; and a standards framework. She also highlighted the need to promote choice, for example in mode, and in the targeting of training. A final session on the use of influence in the inter-agency context "using your energies and the energies of others to make a difference" was led by Enid Hendry.

Opportunities to build networks for those involved in inter-agency child protection training and to share experiences and learning proved to be the aspects of the Symposium most appreciated by participants.

The Symposium was organised by PIAT (Promoting Inter-Agency Training) and hosted by NSPCC.

Enid Hendry, Head of Child Protection Training, NSPCC National Training Centre, 3 Gilmour Close, Beaumont Leys, Leicester LE4 1EZ

"London's Health Care: From Vision to Reality".

This conference, held in November, marked the conclusion of the three year life of the Primary Care Support Force (PCSF), established to support primary care developments in London. Interprofessional education and development, interprofessional practice, teamworking and interagency trust and collaboration were recognised as important factors in achieving high quality, community oriented, primary care led health and social services. Questions and discussions throughout the day often picked up on these themes.

Points made by the panel in response to the questions around overcoming tribalism stressed the need to create a stronger academic base in primary care, to build teamwork into undergraduate and continuing education and to build on and sustain support for the initiatives that are underway. Suggestions for extending interprofessional education included providing evidence of effective outcomes, promoting equitable access for all professions to educational opportunities, emphasising "in- practice" education focused on problem solving and local issues, linking education to organisational development and integrating funding streams.

A workshop on combatting tribalism noted that organisational arrangements, professional orientation and culture and interpersonal communication affected the willingness to work together. Regular team meetings which considered leadership, accountability, roles and ways of working together in a very direct and open way and taking time to develop a shared sense of purpose with clear prioritised goals could help combat tribalism. It was acknowledged that the earlier professionals open themselves to the ideas of others, the easier teamworking processes will become.

Teamwork

This article is an outline of key points emerging for me from two joint events by the Royal College of Nursing and the Royal Society of Medicine. The meeting "Dream Teams: Teamworking for improvement in patient care" was held on 12/11/96 and the conference "Teamwork in a Primary Care Led NHS: Working Together?" was held on 17-18/2/97.

The complexity of human needs often means that no one professional has all the skills necessary to respond. Several professionals need to work together to ensure a wide range of skills are available. The growing fragmentation of healthcare provision also means that collaboration across different organisations is essential. Hence, team working and interorganisation collaboration are essential components of primary care.

Teamwork is just one of the essential requirements for the provision of coordinated care. Adequate resourc-

ing, organisational restructuring, policy linkages between health and social services and the realignment of funding are also crucial in providing a framework and context which encourages and supports teamwork.

A team can be defined as a group of individuals who work together to deliver services for which they are mutually accountable. Characteristics of a team include shared goals, interdependence of the members who achieve results through their interactions with one another, a diversity of skills and knowledge, mutual support and an ability to accept and work with differences.

The barriers to effective teamwork include:

- interpersonal differences
- individuals' feelings of uncertainty and fear of change
- intra- and inter-professional rivalries and misunderstanding
- perceived or real power, income and status differentials
- differing conceptual approaches and models of health between professionals
- lack of training and education about teamworking
- differing management structures and accountability lines
- differing and competing organisational priorities
- the disjunction between operational practice (which promotes collective responsibility) and the legal framework (which fails to support teamwork and does not recognise team legal liability, but sees the members as personally and professionally accountable for their individual actions).

Teams seem to operate most successfully when they have diverse members who each perform different roles. Six to twelve seems to be the most effective size. General practices with their attached staff are often larger than this, and professionals often need to work with larger numbers of people. It is important to identify correctly the occasions when teamwork is appropriate and to use other models of collaborative working for other times.

Much has already been learned about effective teamwork. Components

include:

- shared values, goals and clear objectives which take account of individual members' values and aspirations
- clearly defined tasks for all
- complementary roles which are understood and respected by all
- clear procedures and agreed protocols
- regular and effective communication, including an ability to work with differences and resolve conflicts
- mutual respect and trust
- commitment by all team members
- regular review and reflection on progress and feedback on the performance of the team as a whole and its individual members.

Leadership in teams requires a balance between an ability to involve all team members in a democratic process of decision making, to resolve differences, to forge a clear, and shared sense of purpose and to provide guidance. The role of leader is best rotated or undertaken by the team member best suited for this role. Leadership is different from managerial responsibility and clinical supervision, and involves charisma, innovation, trust and respect, facilitating and coordinating the involvement of all members, enabling them to feel valued and guiding and supporting the development of the team.

Learning to work in teams must be part of the undergraduate and pre-qualifying education of all professionals and must be continued during postqualifying education and continuing professional development. Some of this learning must be shared with other professionals to help develop interprofessional understanding and collaboration.

Changing the prevailing culture to one of teamwork and collaboration will be a long, slow and difficult developmental process. Individuals and organisations will need to believe in the value of partnership with other professionals and with users and carers.

"Sharing the Care Working Together in Drug Use and Misuse".

Despite appalling weather conditions 50 participants from the North and the Midlands braved snow and high winds in December to attend the day. Lecturers representing Midwifery, Community Psychiatric Nurses, General Practitioners, Professional Bodies, Voluntary Organisations and Social Services spoke of their experiences in attempting to support those seeking help to reduce substance misuse and explored the myths that surround drug use, as well as presenting the facts. The importance of tackling identified problems through team working rather than a tribal approach was highlighted.

Key issues regarding the importance of educating both the general public and work colleagues around the danger of illegal drug use were debated. The day resulted in the exchange of many names and addresses and some new networks were made.

Evaluations showed that the participants acknowledged that significant mutual learning had taken place, confirming that professional barriers to communication and exchange of information must be challenged and that more events like this must follow. As one individual commented " why has it taken so long for some of us to simply talk to each other, after all it is not as if we are not on the same side?"

Doreen Kenworthy, Senior Health Lecturer, School Health Studies University of Bradford, Unity Building, 25 Trinity Road, West Yorkshire BD5 0BB

Conflict of Interest-Issues Surrounding Aggression and Violence in the Community

Held in the north of England in October, this seminar was attended by over 60 individuals with representation from Health Care Professionals, Social Workers, Probation Services, Police Divisions and the Voluntary Sector. The key speaker was Diana Lamplugh of the "Susie Lamplugh Trust". Diana noted that too many groups were working in isolation instead of seeking co-operation and stressed the importance of collaboration, communication and multiprofessional education as the starting point for tackling aggression in society. This message was echoed by speakers from the Health Care Sector, Social Services, and the Police.

Several policy papers and reports published before the election give significant support to interprofessional education and practice. CAIPE hopes for increasing support from the new government for interprofessional education and practice and attention to the mechanisms needed to take it forward.

Recent Reports

A Service With Ambitions, a White Paper (October 1996), identified five strategic objectives for the NHS:

- a well-informed public;
- a seamless service;
- knowledge based decision making;
- a highly trained and skilled workforce;
- a responsive service.

The characteristics of the highly trained and skilled workforce considered necessary for high quality responsive services are:

- to see and understand things from the perspective of the patient or carer;
- to be an effective communicator;
- to understand and make the most of the whole health and social care system;
- to work in teams even when they cross organisational boundaries;
- to identify health needs and understand the opportunities for health promotion as well as treatment and care;
- to work with patients and carers ensuring that they can play a part in decisions and choices affecting the treatment or care.

The professional development consultation sought to:

- consider existing policies for professional development;
- consider how best to encourage multi-professional working and effective team working;
- consider how existing partnerships might be developed to ensure high quality standards of education;
- consider the development of NHS education and training budgets.

The consultation, to which CAIPE and many other organisations con-

tributed, has taken place. Some key points emerging from the report by Regina Shakespeare from the Kings Fund of a national seminar to inform the consultation, at which CAIPE was well represented, include:

- Interprofessional education and development are going against the grain of the current system of education commissioning, professional accreditation and professional cultures so the culture shift required is significant.
- Existing innovations are insufficient, without action to tackle structural and attitudinal issues, to make this culture shift happen.
- The question of which educational approaches and methods best facilitate collaboration needs further research and development.
- Leadership, patient-centred rationales, appropriate investment, teaching the teachers, aligning funding mechanisms and managerial and professional body support are crucial success factors.

The report from the NHSE on future developments in light of the consultation is due end June.

"Primary Care: Delivering the Future" (December 1996) suggested an evolutionary approach to change. It recognised that developing partnerships in care would require better interprofessional working, the development of professional roles and the forging of partnerships between Health Authorities, Local Authorities and voluntary and independent agencies. The development of professional knowledge, it stated, would depend on recognising the benefits of interprofessional learning, increasing the proportion of education and training that is multidisciplinary, and ensuring that undergraduates are trained for primary care.

Education, it noted, plays a significant role in forming attitudes. The discontent with current interprofessional work and the failure to collaborate results from different structures, ideologies, orientations, opportunities and educational approaches. It is important to develop shared learning early on, so that understanding of these differences can be improved.

"In the Patient's Interest: Multi-professional working across organisational boundaries" (October 1996) is a report by the Standing Medical and Nursing & Midwifery Advisory Committees. A joint working group considered how patient care could be enhanced by cooperation between different professionals and organisations across health and social care, general and community medical services, primary and secondary care and with carers.

The difficulties caused by fragmentation of services resulting from competition between providers, new administrative systems and the short-termism in planning were noted. The group identified several themes which underlie collaboration and can help overcome barriers. Examples of collaborative working are included. Practical pointers for better coordination and collaboration were identified.

The group concluded that collaboration within and between health and social care services is more important than ever. Recommendations included that:

1. All professionals in health and social services should adopt a collaborative approach to working across organisational boundaries so that patients and carers receive help which is timely, well coordinated, effective and appropriate.

2. Further work on clinical audit is essential in order to improve the outcomes of multidisciplinary practice. Collaborative care requires client centred audit.

3. There should be explicitly agreed procedures for information sharing between professionals from different agencies, based on a commitment to safeguarding the confidentiality of personal health information.

4. All those responsible for the education and training of health professionals and social workers should encourage and support programmes which help them to operate as team members. Efforts should be made to increase the common elements in basic and post-basic education and training for related professions, to famil-

iarise students with the attitudes, values and working practices of other professions. Continuing professional development programmes should also emphasise commonality of purpose, and where appropriate, not be confined to a single profession. Local programmes of joint education and training should be developed.

5. Managers should be committed to effective inter-agency collaboration and co-ordination of services. Strategic planning and administrative systems should support the work of practitioners.

6. Services should be co-ordinated by a named professional, who may be from any discipline, but should command the confidence of other professional colleagues.

7. Commissioners of services should use the contracting process to specify standards for collaborative working and exchange of information and contracts between purchasers and providers should reinforce collaborative arrangements made locally.

Multiprofessional Working and Learning: Sharing the Educational Challenge, a SCOPME Working Paper (January 1997)
SCOPME, 1 Park Square West, London NW1 4LJ

The Standing Committee on Postgraduate Medical and Dental Education (SCOPME) is concerned with postgraduate and continuing medical and dental education in England. This working paper examines the many issues involved in multiprofessional working and learning in the delivery of healthcare.

The paper reveals a complex picture of multiprofessional working and learning, while also identifying certain key concepts relating to organisational and educational contexts.

The working group set about their task by collecting comments in writing and orally from a wide range of people and organisations (including CAIPE) and through two multiprofessional workshops. The group soon realised that additional professions, not just doctors and dentists, would have to be consulted.

The paper recognises that the term 'multiprofessional learning and work-

ing' is interpreted in a variety of different ways and that clarity is needed on this point. Results from the workshops led to more positive definitions of multiprofessionalism such as; a group of individuals from different disciplines and skills with shared values common aims and objectives; co-operation among professionals and a combined approach between several disciplines to problems. It is also noted that a multiprofessional team can not be established until the task in question is identified. The benefits of multiprofessional working and learning and the problems faced when undertaking it are then examined.

Another section is concerned with how multiprofessional development can take place in the context of the organisations that determine how the service is delivered to patients by looking at the patient, the purchaser and the provider manager.

The educational contexts for developing multiprofessionalism are also recognised as all important. The working group believe that incorporating interactive learning opportunities between the professions in existing educational frameworks is vital. However the problems that can arise from this which inhibit effective multiprofessional working and learning such as rigid curriculum structures, the emphasis on single professional values and the hierarchal structure of medical and dental training are noted. There is much more that could be done to help undergraduates set what they are learning into a multiprofessional context. The changes that have already taken place such as medical schools becoming part of larger faculties of health sciences are recognised as good progress.

Perhaps the single most important conclusion reached by the working group is that there is no one right way to achieve effective multiprofessional working and learning. They feel that much of the successes already achieved are down to the efforts of groups of individuals who have understood the benefits of multiprofessionalism for the patient. A set of principles are suggested to help embed a multiprofessional approach into systems for health care delivery. The working group want to hear more about multiprofessional experiences in different clinical settings and

learning examples of where initiatives have been taken at national, regional and local levels.

The General Medical Council has just published **"The New Doctor"** (April 1997) which sets out recommendations to help ensure that the clinical, educational and personal needs of doctors in the pre-registration year are met. While there is no explicit recommendation for interprofessional education, there is some implicit encouragement.

The given aims for clinical training include enabling new doctors to communicate effectively with patients, relatives, healthcare professionals and people in the community, to work in a team (including respective roles and continuity of care) and accept principles of collective responsibility and to understand the relationship between primary and social care and hospital care. It is arguable that to fulfill these aims, new doctors would have to have some experience of working with and learning from other professionals.

In writing about how to bring about the recommended changes, the GMC notes that a change of attitude is required. Examples of resource-neutral innovations are given, including the establishment of committees at which junior doctors and nurses meet to discuss matters of mutual interest and concern.

Including other professions

In March 1997, legislation was completed to enable prosthetists and orthotists and art therapists (including art, music and drama therapists) to create their own Boards under the aegis of the Council for Professions Supplementary to Medicine. This leads on to the challenge of creating opportunities for interprofessional learning and practice that involve these professionals. CAIPE looks forward to hearing of developments.

Dentists and pharmacists are just two professions who play a crucial role in primary care and who, as yet, seem to be frequently overlooked in interprofessional education and practice developments. Perhaps the time has now come when efforts can be made by all concerned to remedy this omission.

There are some examples of shared learning between doctors and dentists at both undergraduate and postgraduate level. A SCOPME report in 1994 studied formal opportunities in postgraduate education for hospital doctors and dentists. It recommended valuing informal, opportunistic learning and developing education programmes, but fell short of encouraging interprofessional learning. While the recent report by SCOPME, **"The Early Years of Postgraduate Dental Training in England: An agenda for change"** (February 1997) also does not explicitly recommend shared learning for dentists with other professions, it does recommend improved communication and collaboration between the branches of dentistry, greater emphasis on health promotion and disease prevention and increased emphasis on continuing education.

79 of the 98 respondents to the consultation questionnaire based on initial commissioned research which informed the final SCOPME report agreed that dental trainees should have the opportunity to train or work alongside other health professionals and that generic skills such as problem solving and communication should form part of training. The main suggestion for achieving joint training included sharing joint training days on particular topics, shadowing other professionals or taking part in exchange attachments.

SCOPME does recommend that these points, along with others such as the need for strategic planning, clarifying the objectives of professional training, improving experiential learning, developing appropriate assessment and for training for the trainers, should be addressed. Many of these educational issues reflect current themes for the development of education for other professions - and provide considerable scope for sharing, debate and mutual support in introducing such changes.

Pharmacists are increasingly expressing an interest in working and learning more closely with other professions. The conference of the Royal Pharmaceutical Society to be held later this year will include consideration of interprofessional education.

Other Influences

Other issues which are currently being considered and which are likely to have a significant impact on interprofessional education include the following. Further details will be given in the next Bulletin.

- The Dearing Inquiry into higher education - due to report in the summer.
- The Review of the Nurses Act.
- Preparation of draft legislation for the PSM Act.
- A review of continuing professional development in general practice, led by the Chief Medical Officer.
- Moves towards integrated workforce planning.
- Plans for establishing National Training Organisations in all sectors, including the health and care sectors, to identify future workforce skill needs, influence the provision of training to meet those needs, influence the training market and the development of national occupational standards and represent the sector to government.

Green Paper: Developing Partnerships in Mental Health

This Green Paper reviews the progress already made in developing successful partnerships between purchasers of mental health and social care services (including GP fundholders), and looks at the ways of building on this to achieve seamless care.

The paper acknowledges the achievements of some health authorities and social services in working together, but also raises concerns that for others there are still problems, such as difficulties in sharing information, different employment practices, lack of organisational flexibility and barriers to sharing resources.

Key features of successful partnerships are said to be:

- a clear vision of service development
- effective leadership and personal commitment
- formal mechanisms for bringing people together and sharing information

- mutual understanding of each other's culture, roles, values, and constraints.

Four possible options for structural change are proposed and written comments have been invited.

The paper is available from **NHS Executive Headquarters**, *Mental Health Branch, R325, Wellington House, 135-155 Waterloo Road, London SE1 Publication Centre. Tel 0171-873 9090 Fax 0171 873 8200. ISBN 0-0135552-1. Price £6.85.*

Interprofessional Collaboration: The Approach of a Regulatory Body

In recent years, major changes in health and social care legislation, advancements in education and improvements in clinical practice, have required organisations to review their strategic and operation approaches, especially, how they communicate and interact with their clients and other organisations. Although this is not an unusual scenario for most organisations, it does have wide reaching implications for Statutory Bodies.

The National Board for Nursing, Midwifery and Health Visiting for Scotland (NBS) responded to this challenge by taking a strategic view of its activities and adopting a proactive approach in developing interprofessional relationships.

The NBS uses a three-tier planning model to assist in the development of interprofessional activities and relationships, i.e. research/education projects, collaborative partnerships and opportunities to share information. This approach also helps to integrate interprofessional work across all areas of NBS activity.

Assessment, planning, implementation and evaluation are undertaken in relation to work planned at each tier. The three tiers are:
Strategic Level - Inter-organisation work at policy level;
Programme Level - Joint projects and other collaborative ventures at operational level;
Individual Level - Activities involving staff, clients etc. aimed at identifying/developing interprofessional relationships.

In 1996/97 the NBS developed a number of pieces of work that attempt to straddle each of these three levels. At the Strategic Level, in conjunction with the Scottish Post Graduate Medical and Dental Education (SPGMDE) the NBS jointly funded and shared in the development of a distance learning package for nurses and doctors on clinical management. The NBS has also been working with the Royal College of General Practitioners (RCGP) and the Scottish Centre for Post Qualification Pharmaceutical Education (SCPPE) on the implementation of practical guidelines for clinicians developed by the Scottish Intercollegiate Guidelines Network (SIGN).

At the Programme Level, The Network Project is aimed at enabling NHS Trusts to explore and develop quality assurance systems and processes to meet the professional preparation needs of their post-registration nursing staff and to share experiences in practice development.

The Nursing Advisory Group was set up at the Individual level to advise the NBS on issues surrounding the education and training of nurses working in nursing homes. It involved bringing together a number of individuals representing the nursing home sector, including registration and inspection, nurse managers and specialist nurses in this area. As consultation had highlighted clear differences of opinion and often discord that existed between some of these groups it seemed appropriate that a forum should exist for a more considered discussion. This resulted in the publication of the leaflet outlining a shared view of good practice in the provision of education and training for nurses who work in nursing homes.

The NBS is committed to working in collaboration with a wide range of individuals, agencies, organisations and professional groups with an interest and investment in the education and training of nurses, midwives and health visitors and looks forward to sharing some of these experiences with you at a later date.

Bill Deans, Professional Officer (Nursing/Community), National Board for Nursing, Midwifery and Health Visiting for Scotland

Developing interprofessional education: the approach of a region

The NHSE South and West has commissioned various multiprofessional education initiatives in the region over the last three years. The purpose of the grants scheme has been to pump-prime and foster innovatory multiprofessional education linked to health care improvement priorities.

Projects applying for funding were assessed against the following criteria:

- the match with NHS Planning and Priorities Guidelines;
- the degree of innovation in education practice;
- the potential for transferability and general application;
- the degree to which the education and training infrastructure is strengthened;
- the dimensions of the scheme - to include interprofessional learning and development, multiagency aspects, professional and management development, personal and organisational learning;
- the extent to which the scheme develops or reviews occupational standards;
- the extent to which the scheme develops new qualifications or pathways to qualifications.

A palliative care project was supported over three years from 1993/4. The first phase involved four general practice and four hospital team members attending two workshops and a conference to discuss issues of palliative care in an interprofessional group. A directory of hospices in the region was produced. The second phase consisted of workshops for professionals from four primary health care teams and seven hospitals. The workshops encouraged consideration of patient needs and responsive, collaborative service provision, sharing information and formulation of a team action plan to ensure future coordination and linking with others.

Major initiatives which have been supported include:

- Bournemouth University to design and deliver a practice-based action learning programme, with academic credit at Masters level, for primary health care teams.

- A consortium of trusts and the University of Plymouth for a Mental Health Services Leadership Programme.
- The Moorgreen Hospital for a project on multiprofessional ways of working.
- The University of Exeter Institute of General Practice to develop new qualifications for a variety of professions and for training programmes for the primary health-care team.
- The University of Plymouth for developing multiprofessional education within primary, community and hospital settings.
- The University of West England to involve key health and welfare professionals in creating a curriculum package to improve and develop collaboration and coordination between health and social care agencies in community care.
- The Cornwall and Isles of Scilly Learning Disabilities NHS Trust for interprofessional profiling.
- The Isle of Wight Community NHS Trust to develop a generic training plan for nursing and therapy aides.
- The University of Southampton for multiprofessional learning in palliative care geriatric medicine.
- The Phoenix NHS Trust for a personal and organisational learning programme for managers and clinicians to develop supportive learning communities within the Trust.
- The Postgraduate Medical Centre in the Royal United Hospital, Bath for a national teachers course in mental health management in primary care.
- The Royal South Hants Hospital for a pilot multiprofessional management development programme.
- Southmead Health Services NHS Trust for a project to review existing training on venepuncture and other forms of basic and advanced life support and develop, deliver and assess new multiprofessional training on these skills.
- The University of Southampton to develop and evaluate an inner city locality based approach to multidisciplinary primary care education.
- The University of the West of England to research and develop a multidisciplinary practice teaching module at Masters Level.

In addition, several small initiatives have been supported.

To support continuing developments, the NHSE South and West will :

- support opportunities for projects to continue networking and sharing information, including through a website;
- evaluate the multiprofessional education programme;
- establish an REDG advisory sub-group to steer the strategic development of interprofessional education;
- explore ways of disseminating the lessons learned.

In addition to the education projects funded by the Regional Office, the following projects with multiprofessional dimensions are underway.

A project in Salisbury to develop occupational standards for community mental health teams, based on service needs in the area and identify competencies that all team members should have, competencies that are shared by two or more professionals and competencies that are unique to each professional.

A project involving several sites to develop occupational standards for breast cancer.

A project in Liverpool is developing competencies in clinical effectiveness and these will be piloted in the South and West.

From these competency projects, it will be possible to identify standards common to several professions and this can be used to help with the commissioning of multiprofessional education.

Contact Steve Annandale, Education and Training Policy Manager, NHSE South and West, Westward House, Lime Kiln Close, Stoke Gifford, Bristol BS12 6SR

New Mental Health Postgraduate Programme in the West Midlands

In September this year multi-professional teams of mental health workers in the West Midlands will have the opportunity of embarking on a Masters programme at Birmingham University designed for those working with severe and enduring mental illness. The programme will be funded, for the first three years by the NHS Executive West Midlands.

The Regional Mental Health Manager, set up a working group 12 months ago to test out thoughts on the need for a new and unique course to reflect current practice and local priorities. The response was positive and, with the support of the local education consortia and REDG, who were consulted from the outset, the original idea was translated into a comprehensive menu of modules which address the key skills and knowledge requirements of those working with serious mental illness in the region. The West Midlands regional office for the NHS Executive were clear that the programme should be multi-professional in its development and delivery.

The specification for the programme set out some key skill areas to be addressed and identified priority requirements to be satisfied including:

- a multi-professional and user focused approach to programme development and delivery
- programme development based on a strong research foundation
- a close and active alliance between the university and a range of service providers
- the target audience to represent the wide range of professions working with seriously mentally ill people
- the programme to be developed with its consumers in mind, offering a flexible and responsive menu of education that demonstrates an understanding of the different needs and constraints of the relevant professions.

The 3 year postgraduate programme is ambitious in content and approach and can be exited at certificate, diploma or masters level. Students aiming for a masters qualification will undertake 13 modules (including a research module) and carry out a work based research project.

The key skills areas addressed in the programme are:

- Person centred assessment
- Evidence based interventions
- User empowerment and collaboration skills
- Evaluation and research skills

Recruitment to the programme will be geared towards teams of 4 from Trusts in the West Midlands with a maximum of 40 students in the first year. The programme is designed for multi- professional target audience including psychologists, nurses, psychiatrists, social workers, therapists and each team should be made up of at least three different professional.

A robust evaluation will be carried out. The evaluation should help to inform education consortia, along with consumers and providers of education, with a view to influencing further developments in mental health education and in multi-professional education more broadly.

*For further information contact **Di Bailey**, Course Director, Department of Social Work, University of Birmingham, Edgbaston, Birmingham B15 2TT Tel.0121-414 5724 or **Antony Sheehan**, Mental Health Manager, NHS Executive West Midlands, Bartholomew House, 142 Hagley Road, Birmingham B16 9PA Tel. 0121-224 4743.*

Joint Validation for ENB and CCETSW Pre-Registration/Qualifying Programmes

The English National Board for Nursing, Midwifery and Health Visiting (ENB) and the Central Council for Education and Training in Social Work (CCETSW) have announced a jointly agreed mechanism for validating joint education and training programmes in nursing and social work at pre-registration/qualifying level. This marks a significant point in the long established history of interprofessional collaboration between the two statutory bodies.

CCETSW and ENB believe that this is an important step forward which will improve collaboration between the two professions and contribute to the delivery of a more effective and coordinated service to the community. The guidance was due to be reviewed in March 1997.

In November 1995, ENB and CCETSW issued a Joint Validation Procedure for Pre-registration/

Qualifying Programmes. Principles of good practice for the preparation of joint submissions were identified and included:

- The submission document should provide a working tool for the implementation and delivery of the programme which is easily accessible to all participants.
- Education providers are advised to consider how to facilitate access to relevant documentation by service users.
- The primary aim of a joint programme is to prepare practitioners to meet the needs of users, families and carers in the context of contemporary health and welfare provision.

It was suggested that an interprofessional approach should be integrated throughout, which:

- identifies common learning outcomes;
- values and develops mutual understanding of the profession-specific elements of the programme;
- underpins the management of the programme;
- translates into common teaching and learning strategies;
- underlines common assessment schedules, systems and structures and avoids over assessment of students;
- informs the training and development of staff responsible for programme delivery;
- ensures that the tutorial system provides students with consistent and non-conflicting support from lecturers from different professions.

It was recommended that the management board for the programme be comprised of senior managers from both professions, the education institution and agency partners who are able to take decisions regarding programme resourcing, so that all felt ownership of the management, delivery and monitoring of the programme.

At present, joint pre-registration/qualifying programmes leading to a Learning Disability Nursing qualification and the Diploma in Social Work are offered at the University of Portsmouth, Manchester School of Nursing, Midwifery and Health Visiting, University of Hertfordshire and South Bank University. Several other courses are under development.

*For further information, **please contact your designated Education Officer (ENB) or Liaison Adviser (CCETSW)**. Geoff Bourne, Director, ENB, Victory House, 170 Tottenham Court Road, London W1P 0HA*

Welsh Institute for Health and Social Care

The Welsh Institute for Health and Social Care (WIHSC) was established in 1995 to facilitate education, research, and consultancy designed to find practical solutions to practical problems in the area of health and social care. The Institute has its origins in the many successes of the Welsh Health Planning Forum, which developed and led innovative approaches to health strategy in Wales, as well as being at the leading edge of health and social care developments within the UK and Europe.

The Institute's work on translating policy into practice is focused on the areas of strategy, organisational development, futures and substitution, all of which directly impact on and influence interprofessional education and training.

A major feature of the Institute's activity is working with health and social care organisations, to think through the organisational and human resource implications of future change. The way in which professionals work and share together, in an increasingly complex context, remains an important item on the agenda for action. Current work on evaluating activities at the health and social care interface, using a rapid appraisal approach, raise a number of education and training issues for professionals operating at that interface.

Research in relation to futures analyses key influences on the future of health and social care, of which an essential component is the future of the professions and their crucial role in determining the effectiveness of service delivery. These influences affect all professional staff currently working in the health and social care sector and will be of increasing importance to future professionals as they embark on, or are engaged in, education and training, whether at qualifying or post-qualifying level.

Another activity is research into the likely future impact of the new genetics on health and social care. A key aspect is the development of innovative approaches to engaging the public in a dialogue about genetics.

Substitution, pioneered by the Institute, involves the systematic examination of ways in which health and social care organisations can re-group their resources, for example their staff and skills, in order to deliver better quality and more efficient care. This approach demands new and closer ways of co-operation.

The Institute's work depends upon its partnerships with the NHS, Social Services, the voluntary sector, educational and professional interest groups, including strong international links. It is a WHO Collaborating Centre for Regional Health Strategy and Management Development in Europe.

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Sainsbury Centre Review of the Roles and Training of Mental Health Care Staff

The objectives of the review were:

- To establish the range of skills required within mental health services to address the needs of service users and carers and the requirements of social policy and legislation.
- To examine the current training of the main professional groups involved in the delivery of mental health care services.
- To identify how far the outcomes of current professional training meet the requirements of a changing service.
- To suggest ways of adjusting professional training to make it more appropriate to the requirements of changed service and the needs of the service users.

The review drew upon a range of sources of information and research, including a paper contributed by CAIPE.

The review considered that training in good practice in multi- disciplinary joint-working must be given the highest priority if resources are to be best discharged for the benefits of the severely mentally.

The report, entitled "Pulling Together" provides useful information on:

- changes in both acute and community based services which impact on professional roles,
- policy and legislation,
- the needs of a changing workplace,
- the funding and organisation of mental health training,
- existing training arrangements for the main professional groups,
- a framework to improve current and future provision.

It suggests that the main challenges for the training agenda are:

- adjusting basic training so it becomes more appropriate to changed service needs and new practitioner roles and reflects agreed occupational standards for professional competence.
- co-ordinating and regulating multi-professional post-qualifying training to ensure compliance with standards of professional competence.

The report identifies core competencies for professionals working in mental health and recommends that occupational standards for each professional group are developed from these competencies. It suggests the Royal Colleges and regulatory bodies consider developing a common, core curriculum for the pre-qualifying training of all disciplines working in the field of mental health based on these standards.

It also recommends:

- Actively resisting creating a generic mental health worker, as separate and distinct sets of professional competencies will continue to be required and that training must deliver those.
- That examples of effective working between Trusts and Local Authorities and primary health care teams are identified and disseminated widely.

- That joint training events be organised to inform organisations about the policies and practices of other provider agencies.
- That GPs and primary health care staff are trained for their new roles in mental health through postqualifying, practice based, multidisciplinary training.
- That disciplines are exposed to each other at all levels of training.

The report also makes recommendations in relation to the training needs of specific professional groups.

The report is available from **The Sainsbury Centre for Mental Health**, *134 - 138 Borough High Street, London SE1 1BB phone 0171-403 8790.*

New Interprofessional Practice Teachers Course in the South East

South Bank University is starting a new course for practice teachers in social work and the health professions in 1997-8, the first of its kind in London. Drawing on the experience of the Joint Practice Teaching Initiative and the programmes already successfully operating in various parts of the country, the course will be open to social workers, occupational therapists, community nurses and other health professionals whose needs it can meet. It replaces and incorporates the well established and highly regarded programme leading to the CCETSW Practice Teaching Award that has been provided by Blackfriars Practice Learning Centre in partnership with South Bank University.

Requests for information and application forms can be made by telephoning Jean Davis, Development Worker on 0171-815 8000.

A New Team Approach to Mental Health in the Community

A new course, Primary Care of Mental Health, has been developed by the Royal Institute of Public Health and Hygiene. It was developed following a 1992 review of mental healthcare provision which concluded that pri-

mary healthcare teams could play an increasingly effective role. The course is designed to help Health Authorities and Boards fulfill their goals in promoting better community practice, enabling the primary care team to deliver a positive and effective strategy for the management of mental illness.

The course consists of three stages, involving team tasks (with comprehensive training materials and distance learning), a team training workshop and a final consolidation of the skills and knowledge which the team have developed throughout the course. RIPHH certificates are awarded to individuals and practices who successfully complete the course.

Contact Jane Whitehead, Pfizer Limited, Ramsgate Road, Sandwich, Kent CT13 OBR

National Occupational Standards for Health Care

Four types of national occupational standards which are intended to be applicable to a wide range of practitioner groups have recently been developed.

The generic standards apply to anyone who is undertaking a particular function in health and social care or elsewhere in another sector.

Template standards describe a process and need to be contextualised in different environments and for different specialisms to have any real meaning because different groups of practitioners draw on different knowledge, understanding and skill to achieve the standards.

Common Standards are truly common to two or more health and social care practitioner groups. It would not matter which of the practitioner groups undertook the functions as the same standards are expected. They bring similar knowledge, understanding and skills to achieve the outcomes.

Practitioner Specific Standards are specific to particular groups of practitioners and in this recent programme of work are developed for complementary medicine practitioners.

Sixteen major groupings, key roles, have been identified across the programme as a whole and within these

there are 87 units of competence.

The following key roles have been identified as forming the foundations of professional activity.

0 The principles and values on which practice is built - promoting and valuing the rights, responsibilities and diversity of people.

1 The development of one's own and others' practice - through planned development opportunities, the integration of research and development into one's own practice and as a reflective practitioner.

2 The promotion of effective communication with people be they users of services, colleagues or the public at large.

3 Building and sustaining relationships with and between people and agencies be they working in the health and care sector or beyond.

Building on and surrounding these foundations is the whole context of professional activity. The key roles which describe this context are:

4 Influencing and developing policies to optimise health and social well-being.

5 Commissioning research to develop knowledge and practice about optimising health and social well-being be this development, implementation or evaluation in focus.

6 Commissioning interventions to optimise health and social well-being whether these are services, projects or activities.

7 Managing organisations, services and activities whose purpose is to optimise health and social well-being - whether these are health and social care providers or those which have an impact on health and social well-being.

8 Creating and maintaining environments and practices which promote people's health and social well-being.

9 Working in partnership with individuals, families, groups, communities and organisations to enable them to address issues which affect health and social well-being - using a range of models from community and personal development models through to awareness raising and externally designed health projects.

10 Enabling people to manage disability and change throughout their lives whether the change is affecting them directly or indirectly.

11 The assessment of individuals' needs and the planning, implementation and review of intervention to meet individuals needs is at the end of the professional activity spectrum.

Following a consultation process there are now discussions with the Local Government Management Board over the publication of the standards and supporting information. Agreements to date indicate that we can expect this to happen in May once the content has been approved by the Health Care Forum of the Care Sector Consortium in April 1997.

It is likely that the following will form the first set of publications stemming from the programme:

- an executive summary on the programme which will be made widely available to publicise the work of the programme and enable people to access the more detailed information.

- an overview document which describes the standards which have been produced in the programme, how they inter-relate and how they might be used. This document will also give a brief resume of the development process and summaries of the key roles and units.

- four publications which are available individually or as a boxed set consisting of the following sets of standards in spiral bound books with word processed disk inserted. These are a) the foundations of professional activity; b) the context of professional activity; c) the range of professional activities and d) sector specific standards for complementary medicine.

The final report of the programme recommended that there should be a three year action research programme to support the implementation of the standards in the field, evaluate their applicability and lead into an updating and review of their content. Further information on how work will be taken forward nationally and locally will follow as plans are clarified.

Editor's Introduction. The case for "why" interprofessional education is important has been considered in recent Bulletins. Before presenting a selection of short articles considering what form/s of interprofessional education are most appropriate and when and how they are best provided, it seems timely, to outline the definition for interprofessional education that CAIPE prefers and uses.

Interprofessional Education - a Definition

Numerous terms are used to describe occasions when professions learn together. This leads to confusion and misunderstanding, which CAIPE tries to minimise by being consistent itself. It therefore distinguishes between:

Multiprofessional Education defined as -
occasions when two or more professions learn together for whatever reason;

Interprofessional Education defined as -
occasions when two or more professions learn together with the object of cultivating collaborative practice.

Defined thus, interprofessional education is a subset of multiprofessional education, distinguished by its purpose. It may be developed within existing multiprofessional education programmes or from scratch. It enables the participant professions to learn and about one another, to develop the theory and practice of collaboration and to develop collaborative skills or competencies. Other characteristic qualities are included in CAIPE's statement of principles.

Support for this definition can be found in UK literature (see Barr, 1996, Barr & Shaw, 1995, Leathard, 1995) and the American literature (see Casto & Julia, 1994). While respecting the use of widely different terms and definitions by other organisations, CAIPE encourages its members to adopt its usage to facilitate clear communication with one another.

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Collaboration through Interprofessional Education?

The Department of Health urges more interprofessional education, presumably in order to generate more effective collaboration between members of the caring professions. Can such a linear relationship be accepted without reservation?

What do we actually mean by collaboration? What aspects of performance and behaviour would we expect to observe, in order to agree that an episode of collaboration has been appropriate and adequate?

What do we know about the requirements of successful collaboration in different tasks and situations? Would the nature of collaboration and, therefore, the required competences be identical during a surgical operation, at a case conference or for care in a patient's home? These are but a few examples of the wide range of situations and tasks which may call for collaboration.

Is there a set of universally required competences for collaboration, irrespective of task and setting?

Once such fundamental questions have been answered satisfactorily, we would need to move on to an equally important and difficult set of questions. On the assumption that human behaviour is influenced by extrinsic as well as intrinsic factors, it would be useful to seek realistic answers to these questions.

What actions are needed at what levels of the political and managerial hierarchy to enable members of the caring professions to collaborate effectively for different tasks and in different situations/circumstances?

Who should initiate and maintain collaboration between the professions at the national and local government/regional levels?

Only when firm policy for inter-agency collaboration has been enacted can management at lower levels be expected to initiate and maintain the implementation of that policy. Only when the means for collaboration include supportive recognition (e.g. dedicated time for interprofessional consultation) and reward for successful collaboration, can a culture of collaboration be expected to establish itself and triumph over the strains and stresses of daily practice

When these issues have been resolved and a realistic policy is in place, all who will be operationally involved in collaboration will need skills in collaboration. It is at this stage that truly effective education interventions will be needed. They, in turn, could only be developed when the earlier questions have been answered.

This entire argument, if accepted, would suggest the need for an overall strategy and funding to be agreed with those who see collaboration as a critical means for acceptable, effective and efficient social service and health care delivery.

Would this include an intersectoral and interprofessional advisory body for political decision making?

Would this body also act as the steering committee for a government funded research and development centre, charged with exploring the sequence of questions posed in this brief exposé?

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Objectives and Objectivity in Interprofessional Education

The object of interprofessional education is to cultivate collaborative practice. The objectives differ. They may be:

- to predispose participants towards collaboration by modifying attitudes and perceptions;
- enhancing motivation or teaching collaborative competencies;
- to effect, improve or extend collaboration by resolving tensions in working relations;
- tackling common concerns or devising joint plans.

Realistic objectives take into account opportunities and constraints imposed by location, duration, structure, stage, theoretical orientation, curriculum content and learning methods.

Location

University-based courses can predispose students towards collaboration; turning intention into action depends upon opportunities in the workplace. Work-based courses can deliver collaboration, where they engage practitioners and managers in tackling issues under their direct control.

Structure

In universities, part-time students are better placed than full-time to apply learning to practice, especially where courses include work-based assignments. These provide opportunities to learn about working relations and, with sympathetic colleagues and managers, to put collaboration to the test. Placements in alternative professional settings are one way in which full-time students may be helped to overcome their disadvantage, but these are the exception.

Duration

The shorter the course, the more focused its objectives and content is likely to be. Work-based courses are invariably brief and task-specific. University-based courses are often longer, allowing time and opportunity to explore collaboration from different perspectives and in different contexts.

Stage

Shared studies during pre-qualifying courses can prevent prejudices between professions, dispose students towards collaboration and lay foundations for mutual learning later. Postqualifying courses then have a foundation upon which to build as they capitalise upon the confidence and competence which participants should by then have found in their respective roles and identities.

Theoretical Orientation

University-based courses are more likely than work-based to be grounded in theory. Theoretical perspectives may be drawn from behavioural, dynamic or social psychology, sociology, education, organisational studies or management, depending upon which discipline or profession takes the lead.

Curriculum Content

Choice of theoretical orientation is reflected in curriculum content, for example, psychodynamic theories to relinquish defence mechanisms (Woodhouse & Pengelly, 1992), contact theory to cultivate mutually rewarding relationships (McMichael & Gilloran, 1984), systems theory to understand interactions and processes, and social exchange theory and co-operative theory to appreciate the significance of interdependence (Loxley, 1997).

Influenced by the mainstream of multiprofessional education, some interprofessional courses mainly comprise common curricula. But value is added, according to opinion leaders, when comparative studies are included (Barr, 1994).

Learning Methods

Many tutors look to students to provide the comparative studies, facilitated by interaction learning methods. These include:

- exchange-based learning eg. debates, games and case studies;
- observation-based learning eg visits and shadowing;
- action-based learning eg problem-solving and collaborative inquiry;
- simulation-based learning eg role plays and experiential groups;
- practice-based learning eg assignments and placements.

United in Common Purpose

Interprofessional education takes many forms. Separately each may be found wanting. Together they hold the potential to realise their common purpose. Where better than CAIPE to put that to the test?

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Starting Early.

The Interdisciplinary Professional Education Collaborative, to which I belong, aims to improve health care by equipping new health professionals with the ability to continually improve the health of the individuals and communities they serve. We recognised that to achieve this, we would have to integrate learning about this quality improvement approach and about interprofessional teamwork into the education of professionals from early on.

Four sites where undergraduate medical, nursing and health administration students learned together were selected for a three year project to develop educational approaches that prepared professionals for integrated teamwork incorporating continuous quality improvement. The four sites found the most powerful learning was experiential learning from involvement by students in real projects. Projects were mostly ten weeks long and included functional assessment of patients undergoing hip replacement, improving the process for postdischarge follow up for patients with congestive heart failure, community based hypertension screening, improving diabetes care in an urban health center and improving access to well child care.

From this programme we have learned about the importance of:

- matching classroom learning to current project activities, so integrating theory and practice;

- developing team skills requires practice and time for reflection;
- multiple methods of communication can help bridge the barriers of timetables and geography;
- durable interdisciplinary learning may require a change in the educational infrastructure;
- learning goals must be clear and frequently repeated;
- thinking of change as a series of learning cycles;
- making interdisciplinary learning core and essential not elective.

We've learned that when people work together on real tasks that they care about the disciplinary bariers fade away.

Dr Linda Headrick, Case Western Reserve University, Metro Health Medical Center, Rammellcamp Building, 2nd floor, Cleveland, Ohio USA 44109-1998

Developing shared learning for medical and nursing students.

This article describes the process and identifies some of the issues raised whilst developing a programme of shared learning in primary care for medical students and student nurses. Three important factors influenced the development of the programme. Firstly, collaborative working between health and social care professionals in primary care is fundamental to current health care practice (Wilmot 1995). Secondly, research highlights many barriers to collaborative working and recommendations emphasise the need for shared learning (Field and West 1995). Thirdly, although there are some who contest introducing shared learning at prequalifying levels (Barr 1994), there is a growing recognition that identification of common knowledge and values, and valuing each other's roles (Barr 1994), reflect the competences that must be developed at this level to enable the practitioner to meet today's health care needs (Oswald 1996).

In January 1996, the Faculty of Healthcare Sciences was set up through the collaboration of a new university (Kingston University) and a traditional London medical school (St. Georges Hospital Medical School). This organisational change gave the impetus for the development of new educational initiatives crossing professional boundaries. This pilot was developed for 3rd year medical students and adult branch student nurses in their final semester.

The aim of the programme was to examine how people work together, including clarification of roles, responsibilities, potential overlaps and tensions, and how to overcome these, and during this process to explore perceptions and stereotypes. Medical students and student nurses were placed in pairs in General Practice and undertook their shared learning in clinical settings and Faculty based seminars.

As in any shared learning initiative, the developmental process was lengthy and involved:

- negotiation with academics, and practitioners from both disciplines;
- curriculum planning by a small team of GP and nurse academics;
- consultation with and preparation of practitioners;
- preparation of students.

There were a number of important issues raised during the development phase:

- The programme had to fit into two curriculum frameworks, and two cohorts of students concurrently undertaking placement in primary care had to be identified.
- The length, timing and a proportion of the content was dictated by the medical student's curriculum as their placement was considerably shorter than that of the student nurses.
- The student nurses had already completed five weeks in the placement prior to being joined by the medical students, and were at a more advanced stage in their education and training.
- Different language was often used. For example, GPs take a history while nurses collect information for assessment purposes and nurses identify ill health problems while GPs make a differential diagnosis.
- 'Process or outcome' ? Academics needed to identify ways of helping students to focus on the process

of their experiences together rather than the outcome. What had they learned about undertaking a joint assessment of a patient rather than what information had they collected about the patient?

As well as the development work carried out by the academics, there was detailed consultation with, and preparation of practitioners (GPs, District Nurses, Health Visitors, Practice Nurses). This comprised two formal meetings and regular written information. All guidelines were distributed for comment and practitioners undertook lengthy groupwork to identify how they worked collaboratively and how they would teach this to students. Major issues for practitioners included:-

- time commitment and the need for extra time to facilitate two students;
- support in the form of clinical help or remuneration;
- effective teaching of students from another discipline.

These issues reflect the 'real world' nature of this programme and any limitations will be highlighted in the evaluation.

The student pairs were introduced and given guidelines one month prior to the programme and many took the opportunity to exchange telephone numbers, establish contact, and plan their practice timetables in more detail. The timetables were built around a two week period in which the following shared learning took place:-

- a joint session with each practitioner;
- a joint visit to assess a patient in their own home with planning and feedback sessions;
- three Faculty based seminars;
- an assessment by TOSCE.

To examine how professionals work together, observation and problem based teaching and learning methods were used. This reflects the move in both medical and nursing education to use methods that will develop flexible critical thinkers who learn effectively (Margetson 1996). Students were encouraged to discuss their observations informally and to identify both common ground and differences in emphasis/opinion. Seminars

were based upon case studies and students worked in their pairs to problem solve.

Data is currently being collected to inform the evaluation of this programme. Initial feedback from both students and practitioners is positive although most medical students felt that they would have benefited more by undertaking the programme at a later stage in their education.

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Multi-professional Shared Learning: the Liverpool Approach

These are exciting times for educational change at the Faculty of Medicine at The University of Liverpool. Problem-based learning is being introduced in the Medical School and the first year of the Dental School, and degree courses are also offered in Occupational Therapy, Physiotherapy, Orthoptics, Therapy Radiography, Diagnostic Radiography and Nursing. Uniquely, Liverpool has appointed a lecturer with strong experience of both education and health care to facilitate the introduction of shared learning between these professional groups. The learning climate necessary for collaboration appears to be in place, for example, through the adoption of adult learning principles, small group learning,

early integration of theory and practice, elements of formative and summative assessments and the use of cases to trigger learning activities. Courses are validated by both the University and Professional bodies and are either modular or thematic. This dynamic context of educational change however, offers both opportunities and barriers for developing shared learning. The introduction of shared learning across a range of under-graduate courses will heighten awareness of these barriers during the various stages of planning and implementation.

At Liverpool our first major innovation is the development of a two-day pilot course for thirty- two final year students from seven of the above professions, a Foundation Course in Health Care. Ownership of all aspects of course development was conferred on a multi-professional steering group consisting mainly of heads of departments. Decisions about aims, content, educational process, organization and evaluation were decided by this group. We asked ourselves:

- what did we want students to experience from this particular shared learning activity and why?

- what would be the most appropriate learning methods to use?

- how could we involve students to maximum effect in learning activities?

- how could we relate their learning to future professional practice?

- what should we evaluate, and how?

Apart from educational questions, there were also many practical ones, such as;

- which students should participate?

- where should the course be located as several rooms were needed?

- should students be given a certificate?

- were external contributors needed and would they need to be paid?

- what catering arrangements, if any, do we need to make?

These questions would need to be asked whatever shared learning is being planned.

The overwhelming success of the course was apparent from data resulting from the evaluation. Participating students

will be followed through to professional practice to examine changes in their perceptions and attitudes.

The challenge now, however, is to find ways of extending these opportunities for shared learning to all students rather than the small number who participated in the pilot course. Some of the difficulties encountered during planning will remain, for example, the geographical location of departments and student numbers in each profession. These vary in each year group between over two hundred in medicine and under twenty in therapy radiography. Other barriers could be overcome in the long-term through a more flexible approach to curriculum planning, increased communication and understanding between departments, and by sharing valuable resources. This is not to deny that other serious difficulties exist, for example, pressures of time, and the system of departmental funding which rewards research activities above all else. To resolve some of these difficulties a Faculty workshop on shared learning is planned and will be followed on the27 and 28 November by an international conference on multi-professional learning.

The way forward for us at Liverpool is through the formation of a reconstituted cross-Faculty multi-professional group to further identify and develop opportunities for shared learning and collaborative research. The radical changes taking place in the Medical and Dental Schools are encouraging us to explore multi-professional Special Study Modules, community placements, clinical attachments and the establishment of dedicated and regular multi-professional activity days co-ordinated across the Faculty at regular intervals. Other opportunities exist in the communication skills course where dentists learn with doctors and where future involvement with nurses is planned.

Our experiences thus far at planning and implementing multi-professional shared learning have enabled us to identify a number of key factors needed for success :

- support at the most senior levels;

- joint ownership of change by a multi-professional steering group;

- careful and thorough planning and organization;

- clear and communicable aims and objectives;
- good informative documentation both prior and during the course;
- content and learning methods appropriate to practice which are both stimulating and challenging;
- use of contributors as role models with recent and relevant experience of multi-professional working;
- enthusiasm and commitment of facilitators and leaders;
- recognition for participants;
- need for a common understanding of shared learning across the Faculty;
- workshops to facilitate this understanding;
- effective evaluation useful for future development;
- research to complement activities;
- a facilitator/co-ordinator for shared learning with substantial educational research and development experience.

Glennys Parsell, Department of Health Care Education, The University of Liverpool, Tel: 0151-706 4291, Fax: 0151-706 5876, Email: petal@liverpool.ac.uk

Teaching the Teachers : The East Anglian Interprofessional Practice Teaching Programme at the University of East Anglia

This programme is intended for the practice teachers, clinical supervisors, trainers and fieldwork educators who supervise pre-qualification students, trainees and registrars in the workplace.

It aims to develop understanding of, and skill in applying, adult learning theories, to explore individual and professional values, and to facilitate personal and professional development. It also aims to develop understanding of the roles and work practices of different professional groups.

Candidates are drawn from the following groups working in health and social work settings: clinical psychologists, hospital doctors, GPs, nurses, midwives, occupational therapists, physiotherapists, social workers and probation officers.

The programme is managed by a partnership of purchasers and providers which meets regularly. The purchasers are representatives from Social Services Departments and NHS Trusts in the region who will buy places for their employees and the providers are academics from all the professional groups involved.

Candidates undertake up to three Units of study, each of 60 hours, extending in total over a 7 month period. They submit a portfolio of their practice teaching for assessment and, if successful, can gain professional and academic credits.

Why an Interprofessional Approach?

In the early nineties the Schools of Health and Social Work at UEA identified the training of practice teachers as a common area of interest. Perhaps responsibility for programme delivery could be shared, and closer working relationships could enrich us all? The School of Social Work already provided a successful practice teaching programme and an interprofessional programme could build on these strengths, provide a wider and more secure financial base and increase understanding amongst practice teachers of the roles of other professionals.

Important Aspects of the Planning Process

1. Gaining funding to pay for a researcher to develop the programme. In 1995 an application to the UEA Innovations Fund was successful and financed a six month study to research the following areas:
   i. Evaluations of similar programmes already in operation.
   ii. The learning needs of candidates on the current social work practice teaching programme and of potential candidates from all 9 professional groups.
   iii. The training requirements of potential purchasers for their practice teaching employees.
   iv. The changes which would be needed in the academic framework if all candidates were to access the programme at the appropriate level (i.e. Master s or Bachelor s level 3, and arts or sciences) and gain academic credits.
   v. Whether the professional bodies representing all the groups involved could validate the programme for professional credits and, if they couldn t, how this might be achieved in the future.

2. The development of good working relationships by members of the planning group who shared a commitment to interprofessional teaching and learning. All were willing to adopt different ways of doing things and to work flexibly in an atmosphere of continual change.

The research undertaken during the feasibility study suggested that it was important to build flexibility into the programme in order to meet the needs of different professionalgroups.

For example, most health professionals tended to feel that 5 days was the maximum they could spend away from their office on a teaching programme. They also tended to prefer teaching on a regular day each week as this suited their work pattern and linked with the Msc in Health Studies which most of them would be undertaking. Social Workers, on the other hand, were required by their professional body to undertake all three programme units and preferred teaching delivered in blocks.

All professions were clear that, whilst many of the curriculum topics could be learnt in an interprofessional context (e.g. adult learning theory, reflective practice, issues relating to supervision and assessment and to personal and professional values), others should be learnt uniprofessionally (e.g. specific techniques, helping to integrate theory and practice, planning the placement and providing appropriate learning opportunities). They also wanted a mix of more formal teaching, workshops and learning from peers.

The 1997-1998 programme is now being planned and Unit 1 will have an initial two block days of interprofessional teaching (introduction, adult learning theory, values), followed by three days of uniprofessional teaching (block for social workers, consecutive Wednesdays for health professionals), and then by a concluding interprofessional day.

Conclusion

Planning and delivering interprofessional teaching and learning is a daunting task. Sometimes the difficulties - the differences - are so many and so great that it seems almost impossible to meet the needs of user candidates and of the trusts and agencies which purchase their places.

Yet the process of working together for all concerned, whether purchasers, providers or practice teacher candidates, can be an enriching and enjoyable one. And perhaps we have no choice but to continue to work towards increasing our understanding of, and respect for, other professionals in whatever way we can, in order to ensure that we work together effectively to help patients and clients, and their carers.

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Planning and providing a postgraduate Masters course

The key messages learned while planning and providing a Postgraduate Diploma/MSc course in Collaborative Community Care over five years have been:

- the need for continuing commitment from all involved;
- the need to continuously work at it and review and evolve plans;
- to accept that it is necessary and permissible to make mistakes sometimes;
- evaluation should not be finalised too soon and should emphasise process and outcomes;
- a clear methodology needs to be developed and articulated.

The realities of collaborative practice are reflected in and influence the course. They include:

Diversity. The students are varied and different. They come from different professional backgrounds and work settings; have different knowledge bases; come from different locations; having different past experiences of caring themselves and have different personal experiences of learning and future hopes. There are differences of race, culture, gender, age, sexuality, ablebodiedness and religion.

Commonality. All have met the entry qualifications, have interest in and experience of community care and understand and support the course philosophy.

Uncertainty. The course is part-time, so in their work students are experiencing conflicting imperatives, uncertainty and change, financial constraints and restructuring. This affects their learning and the course, as do the links between their own development and that of their employing organisation.

Developmental Approach. The educational process is a key component of the quality of learning. A methodology which addresses these themes and links the quality of the educational process with stated outcomes in an interprofessional and interagency context is needed.

Key principles are:

- Interdisciplinary work needs to be explicit in the course "philosophy" and linked to the recruitment and admissions strategy.
- The concept of working together needs to be established in the design, implementation and evaluation of the course.
- The primacy of practice must be acknowledged in the learning methodology.
- The process of the learning is as important as the "knowledge" learned.
- The learning process draws on a theoretical base (eg Kolb, Schon, Tripp).
- Celebrate diversity.
- Work with collaboration and conflict, encourage skills which map and manage "professional" boundaries.
- Develop critical evaluation skills with students in the context of interdisciplinary work, as this enhances research and adds value to practice.
- Dispel myths about the uniformity of outcomes.
- Recognise that the alumni are "consumers" and are the best adverts for employers about the value of interprofessional learning.

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Developing Masters Level Interprofessional Education

The Institute of Health and Community Studies at Bournemouth University has recently designed and validated an MA Interprofessional Health and Community Care.

As an academic school we are strongly practice-oriented and staff members come from a wide range of academic and professional backgrounds such as social work, education, health promotion nursing, sociology, midwifery, psychology and management studies.

As a team, we were interested in designing a course with a distinctive identity which drew on our strengths and interests, as well as on the needs of practitioners who are interested in interprofessional issues and advanced practice. I will briefly describe some of the thinking behind the philosophy of the course, its structure, and some reflections about interprofessional education.

Philosophy

A number of us were particularly interested in the theoretical underpinnings of interprofessional care. We began with the question of how we could honour the distinctiveness of our unique professional disciplines and practice contexts without obscuring the ground that we share and the focus on care as a fundamental issue.

The education implication of this thinking resulted in an approach which focused on the person of the professional - that is, on the question of what education experiences would empower practitioners to have the vision, flexibility and skills that could enhance interprofessional collaboration.

It also focused us on considering the nature of integrated conceptual frameworks that would support the theoretical empowerment of interprofessional care. In our view, this focus is exciting and challenging, as there are important existing concepts from different disciplines which can

be tapped, but which still require explicit linkage with the themes of interprofessional care.

Developing all this further, we considered how this approach had a slightly different emphasis than traditional management concerns and how interprofessional development required changes in personal world- view and the unquestioned assumptions that we enact. As colleagues, a number of us engaged in reflective groups that questioned the metaphors and models that we had learned, and considered how this was supportive or restrictive of interprofessional development.

It is this educational experience that we wish to extend to prospective participants in the Masters course.

Structure

The MA is a two year, part time programme which wishes to target practitioner from a wide variety of backgrounds in health and social care.

The content of the course focuses on areas relevant to interprofessional care. It includes a number of mandatory core units which define important contextual issues such as socio-political context, enquiry and research, and philosophical frameworks. A number of option units provide the opportunity to explore relevant interprofessional task and role skills in greater detail, for example, quality improvement, health promotion, and professional education.

The process of the course requires participants to reflect on their practice and to pursue and assignment within each unit that links theory to their practice. Participants come together to exchange the outcome of their discoveries and to give each other insight into the challenges of working interprofessionally within their particular contexts. In addition, each participants pursues a research dissertation relevant to interprofessional development.

Some Reflections

In my view, Masters level study is a good place to pursue interprofessional themes. This is because practitioners with a least three years experience, and equivalent of a B degree, are often secure enough in their professional identities to feel that they are bringing some of value to the

interprofessional arena. Also they have usually had experiences which impress upon them the value and challenges of interprofessional care-for them, it is not just theoretically a good idea.

Secondly, a University provides a good context for this kind of reflective practice. This is because the University and the practice context can, together, provide a creative tension in which a balance needs to be achieved between broad academic enquiry and specific practice experiences.

My final reflection focuses on the question of whether interprofessional learning is best served by practitioners who work with one another. Although the reflect on their practice, our MA course takes practitioner out of their context to meet with other practitioners form different environments. I believe that this is a good place to start, but not a good place to end. It is a good place to start as it gives participants the freedom to explore the issues without getting too bogged down in very challenging political, economic and operational issues. However, as such opportunities become more widely spread, the real test for interprofessional education may rest on further development of educational models in which people working together, cross traditional boundaries to learn together.

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Changing the Mindset - Preparing Staff

The unique opportunity and experience of creating a School of Multi-Professional Healthcare arose when the North London College of Health Studies integrated into the Middlesex University in 1995. The School sought to develop a portfolio of quality interprofessional healthcare academic programmes to meet the changing needs and funding mechanisms of the National Health Service. Our experience to date has been challenging, exciting and demanding!

We began by clearly articulating our vision, aims and objectives. We aim to:

- provide one stop, high quality, research and practice-based healthcare education and training programmes to meet the needs of most healthcare providers, consumers and commissioners.

- have a central focus on "interprofessionalism".

- provide open access, flexible programmes that enable practitioners to work across professional boundaries.

The School staff developed an InterProfessional Healthcare Model which aims to coordinate the specialist skills and practices of different professions to enhance effective and sensitive client care. The model views the client as the catalyst who initiates the interactions within the multi- professional team and is central to all interventions that take place.

For us, teacher preparation has been crucial. Prior to the starting date of the new School the identified staff were written to and welcomed. The Head of School met them individually to discuss anxieties, aspirations, understanding of the "interprofessional" concept and views on how to nurture the School. The School's vision to provide interprofessional healthcare education programmes attracted both cynics and enthusiasts. This was understandable because all teachers had so far only been involved with uni-professional nursing or midwifery education. The concept of interprofessional working and learning was new to them.

We found that professionals are far from ready to shed their uni-professional cloak. Staff were also still coping with the new demands of moving into the higher education system. The cognitive changes they had to cope with included the need to continue delivering existing educational contracts, learning the HE culture and developing their own interprofessional mindset.

Staff recognised that "interprofessionally" informed teachers are needed to develop and promote interprofessionally grounded education programmes. Just talking long enough about interprofessionalism does not enable us to teach interprofessional programmes. Those who really believe that interprofessionalism is basic to the nature of healthcare prac-

tice will be better able to transform practice from uni-professionalism and help develop substantive inter-professional theories and models. We decided to try to integrate the concept of interprofessionalism in all staff and throughout all our education so that it becomes intrinsic to a healthcare professional's learning, practice and thinking.

Given this challenge, the School put priority on acquiring the means and processes to deconstruct the staff's existing cognitive frameworks and immerse them into interprofessionalism. The immediate goal was to operationalise the concept of interprofessional working in the delivery of health care and to stimulate interprofessionally focused research.

"Interprofessionalism" is a new and evolving discipline, however, and we found a paucity of grounded theories to work from. We did find some literature citing "interprofessional" working and learning and these provided models and a starting point for discussions. (Leathard:1994, Soothill et al:1995) We also found a dearth of available interprofessional experts both within and outside the faculty.

Changing the mindset of a large group of staff who had worked and taught in a mono-professional environment for most of their professional life so far, has been a major learning process. We planned several School meetings. At the first one, staff were offered draft papers setting out the School's vision, mission statement and values which would underpin the objectives, academic plan and staff development plan. Reflecting on this and discussing it, enabled staff to subscribe and own the vision, values and the interprofessional healthcare model. Several staff development days were organised very early on. External experts were invited to discuss the concept and the implementation processes of interprofessional working and learning. CAIPE contributed to one meeting. A "get to know a PAM" scheme was introduced. Each staff member was to befriend one or two non-nursing professional colleagues to get to know and understand them and learn about their professional education and work experiences, values and professional development opportunities.

The education development programmes sought to unlock opportunities. Much use was made of conferences/workshops, courses/programmes, School Away Day events and in-house study days.

In addition, the School developed several functional roles designed to empower colleagues, to enhance peer support, and to facilitate sharing good practices or ideas. We set up an academic forum which runs fortnightly during the lunch hours. We are developing and monitoring a skills bank to ensure that the School has the core and quality skills to maintain the momentum of the development, delivery and management of our programmes. Every vacancy is scrutinised and reviewed to match the School's strategic plan. We emphasise appointments of practitioner- lecturers to enhance the credibility of practice-based programmes.

The School has made significant progress since its creation. The selective and focused education development opportunities have enabled staff to develop heightened interprofessional sensitivity; to examine their uni-professional perspective and to accept other professionals' contributions as equally valid. The School's activities are now integrated and staff work across each other's domain. The professional mix of academic staff has changed significantly and now include lecturer practitioners in podiatry, nutrition, physiotherapy, Traditional Chinese Medicine, reflexology, homeopathy, health and safety and others. We are beginning to make an impact among service colleagues. Five interprofessional undergraduate and masters programmes have been identified and are being developed, and the School's MSc Interprofessional Healthcare starts in February 1997 pending programme validation.

The last eighteen months have been a tumultuous period for the School staff. Given the nature and complexity of their work, the school staff responded very positively to the challenges. They were able to adopt and subscribe to the policies pivotal to the School's future development. They invested considerable effort, energy and emotions in nurturing the School's growth and development.

Several conclusions can be highlighted:

- The clear vision and plan the school staff have developed together have enabled us to operate openly with fewer inhibitions. We are more willing to learn from each other.

- The transition from mono-professional mindset to interprofessional working and learning discipline had a slow start but is now at cruising speed. The momentum to achieve a lasting interprofessional integration is now in place.

- Many of us value and readily undertake critical discussions on the merit of developing the interprofessional discipline with other academics and healthcare professionals. This was clearly demonstrated during the School's first master's validation meeting with a panel of external experts.

- The cultural adaptation into HE has also been eased by the appropriate staff development support.

- There is marked increase in commitment to the School's education provisions, highlighted in the marked rise in teamwork between staff.

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Planning and providing team learning activities in a general practice

Interested practice team members meet for an hour on Tuesday morning for educational activity. The practice values the development of all members through education and training. The process of these sessions is seen as a priority. All team members help plan the PGEA approved six month educational programme. Objectives for each session are identified and how these are to be achieved is outlined. The programme includes external speakers, critical case analysis discussions, reports on studies and activities team members are involved with,

discussions on Journal articles and reviews of practice activities. A written record of tutorials is kept on a file.

Elements of the success of the sessions are as follows.

Structure.

- a conducive environment and existing commitment to teamwork and to learning;
- protected time - that is unassailable and constant;
- established communication pathways, both formal and informal;
- readily accessible educational resources;
- integrated with other practice-based learning.

Process.

- all team members are involved in identifying the need, planning the programme, facilitating /teaching, chairing the meeting and reflecting on the content;
- cooperative teaching;
- the benefits to teamwork of the learning are made explicit;
- a diary of activities is maintained and activities are enjoyable.

Content.

Learning activities are designed to be relevant to patient care, individual professional development and enhanced teamwork.

Problems faced include the following.

Structure.

- the timing reduces ready access for all and limited time is available;
- optional attendance weakens the benefits to the team.

Process

- perceived/real GP domination creates barriers;
- the benefits of the process are not given priority by all;
- the diary is incomplete and formal reflection/evaluation is infrequent;
- there is a need to develop improved educational skills;
- there is a lack of common language between all participants.

Content

Poor preparation reduces the benefits and uniprofessional topics seem irrelevant to others.

Plans to build on these foundations have been made and include:

- obtaining evidence of achievement which supports development objectives;
- establishing a second protected education session;
- introducing a formal reflection and summary sheet for each session;
- facilitating the development of clinical supervision between GPs and nurses.

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Locality Learning

From a lecture to a locality based specialist nurse: how did it happen?

Colne Valley Education is a multiprofessional, locality education group with a commitment to learning together and improving care together. The project on Parkinson's Disease consisted of two teaching sessions: at the first, the local neurologist gave a talk on Parkinsonism, and four local patients with varying grades of disability were demonstrated. The audience was multiprofessional.

A course pack had been produced which consisted of reprints of journal articles, material from the Parkinson's Disease Society, and summary notes written jointly by a local GP and the neurologist.

At this session, one of the practice managers suggested that the 5 practices of the Colne Valley put together a collective register of patients with Parkinsonism. This task was undertaken and 49 such patients were identified. (Prevalence figures from national studies suggested that we should have 50 patients for our population of 28,000). Meanwhile, the neurocare team from Colchester was assessing 6 of the patients.

Then, at a second session, the neurocare team gave a talk, illustrated by videotapes of these patients, to show how rehabilitation services could help walking, feeding and speaking.

After this the local health professionals, with the neurologist and the neurocare team, sat in a large circle and discussed ways we could improve services to our patients.

It was agreed that an annual review of each patient was a good way forward, as it would help to identify patient (and carer) needs. This would have to be combined with a degree of organisation in the practices and further education for the appropriate members of the team.

After further informal conversations, it was thought that this project would be more likely to be successful if one health professional in the Colne Valley were to be made responsible for each patient's periodic review. Such a person would:

- work cooperatively with other health professionals in the locality who carried responsibility for the patient;
- understand the condition sufficiently to know when it might be appropriate to alter medication,
- bring in rehabilitation services, help carers and so on.

Ownership of this development had to be as wide as possible and the district nurses were asked to undertake a review of the proposal. They suggested the following pros and cons:-

Pros

- The person would be up to date and have a wide knowledge base of the disease, and would understand and be able to use secondary care services appropriately.
- The person would be a source of expertise.
- This would help make primary care services more effective.

Cons

The person would be yet another health professional, covering five practices who all work differently.

The proposal

With this endorsement of the plan, a proposal for funding such an appointment was put together. The Parkinson's Disease Society agreed to fund 50% of a one day a week post and the practices agreed to fund the other 50%. The Society also agreed to help towards the funding of the training of the new appointee. We are now looking for a local district nurse or community hospital nurse who will combine this one day a week post with their

other duties. So, for fifty days a year we will have a nurse who will work with these patients and their carers, will liaise with their general practices, who will liaise with the local neurologist, geriatricians, social services and neurorehabilitatory services.

The connection between learning and service development

What started as an educational adventure has ended as a commitment to improve services to the patients in our community in a very definite way. The learning organisation which wanted to learn about Parkinson's Disease is the same as the working organisation with responsibility for these patients. This is the strength of locality, multiprofessional education, for the learning can be made to have real relevance to patient care.

What is a locality learning group?

Lying at the heart of primary care is the patient, a human being like all of us, whom we, in primary care, are most likely to meet at times of suffering. In order to care for the patient, we need to understand the illness, understand the possibilities and limitations of treatments and interventions, and understand our contribution (as individuals, as members of teams, and as partners of our patients) to the care of that patient.

The daily life of those working in primary care involves a virtual submersion in a mass of complex and demanding patient problems. It is difficult for health professionals to use this experience (which might be described by an optimist as rich and by a realist as chaotic) as a basis for learning, as there is little tradition of so doing. Outside agencies (government or public health departments) have defined areas for improving care eg. health of the nation, mental health, cancer. Perhaps, few primary health care teams can take on the challenge of learning and thinking about these areas under their own leadership and direction, so strong is the tradition of being taught by others.

Here I describe two projects where a multiprofessional, primary care learning group has taken on the challenge of using work-based learning as a focus for improving patient care.

Over the last three years a multiprofessional, locality learning group has grown up in an area of N Essex, known as the Colne Valley. It now has a name - Colne Valley Education. 5 practices who had traditionally worked closely together and served a well defined geographical area started to formalize their relationships together - firstly by becoming a non fund holding commissioning group and then by becoming a fund holding group.

Alongside this re-alignment of the practices identities, there grew the need to think cohesively about patient care, so that services to patients could be improved. Much has been said about the role of purchasing in primary care as a way of creating improvements in patient care: far less is written about the role of learning together as a way of thinking creatively about patient care.

I will describe the cancer project which was undertaken last year to illustrate all these points. The project was set up by the committee of Colne Valley Education as a case based approach to thinking and learning together about cancer.

A team was recruited from each of the 5 practices in our group. Each team was multiprofessional (including reception and practice management staff.)

During the project, there were four meetings for all participants over a six month period, and individual teams met as often as they needed to work on their own case study. Most of the work on the project was covered in a self-directed way but within a defined course structure and programme. There were five steps:

Step 1:definition of professional role - working in groups, without leaders.

Step 2: understanding our experience and the experience of others. In this session we used patient s relatives and role play with a patient actor to further understand the nature of the patient s experience, and to look again at the differing but important roles of GP, nurse and receptionist.

Step 3: working up and presentation of the case (each team had selected an actual patient in the care of whom most of the practice team had been involved) - the preparation for this Step was done by each team outside the main course structure.

Step 4 : input from expert resources - a consultant oncologist and from written resources, including a course textbook *Cancer Care in the Community ed Barry Hancock: Radcliffe Medical Press*. Participants resourced their own learning needs as they felt appropriate.

Step 5: working in group and plenary discussion to tease out the lessons of the experience. The final group sessions which were facilitated were tape recorded and transcribed for research purposes.

From these final group sessions we know that the project helped participants to think holistically about the care of cancer patients, to think about patients needs, to think about the humanitarian side of cancer care, to understand better the roles of all members of the primary care teams, to voice a connection between personal feelings and experiences of caring for cancer patients. There was evidence of an improved knowledge base in some aspects of cancer care (different areas for different participants). Foremost, there was a critical view (often very critical) of what the hospital service was doing in terms of communication with patients, their families and the primary care team. A commitment to improve care for our patients in ways which were within our power was a firm outcome of the project.

Judging by our previous project this last aim may well be achieved, through our plan to work with the hospital services to improve communication, and through our better understanding of our roles responsibilities in primary care.

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Interprofessional Shared Learning and Practice in Primary Care

What is the relationship between interprofessional learning (IPL) and interprofessional practice (IPP)? Assumptions that there will be an improvement in the quality of the services on offer and client care are often thwarted when clients and their carers express their dissatisfaction

with the services provided or when tragedies occur, due to lack of inter-professional co-operation and collaboration. It is not surprising, therefore, that there is scepticism detected among members of the different health and social care professions about practitioners' ability to work well together and of their ability to transfer from joint learning situations to everyday practice. This highlights not only the need for more shared learning during professional training and within continuing professional development programmes, but also the need to systematically and routinely evaluate the impact of IPL upon IPP.

A joint initiative to explore an innovative approach to IPL and to evaluate the impact of this on IPP has been developed between various organisations. The project team comprise an interprofessional group, bringing together expertise and experience from the Primary Care Education Centre (PCEC), within the Ealing, Hammersmith and Hounslow Health Authority, the Schools of Health and Social Work at Anglia Polytechnic University, the West London Health Promotion Agency and CAIPE.

The project, which started in February 1997, aims to promote interprofessional learning, within a framework and process of shared learning by the main stakeholders in primary care, in which the participants themselves take significant responsibility for planning and running components of the learning process, and thus create individualised, yet academically credited programmes at PCEC and at APU. Hence the process is problem - focused and enables participants to identify practice needs as well as their own learning / continuing professional development (CPD) needs, to set their own and their interprofessional groups' learning agendas, in order to address issues and resolve problems. This could lead to designing and implementing an IPL programme.

The project involves 5 groups, identified as follows: (1) GPs, (2) local authority and health authority staff, (3) service users, (4) voluntary agency staff which involves organisations for formal and informal carers, and (5) private sector workers.

Group tasks focus on the topic: "Mental Health: The Promotion of Well Being and the Provision of Services for Older People". Initial group meetings use a case study as the stimulus to discuss obstacles to inter-professional practice and identify learning needs, in preparation for meeting the other groups at an IPL study day, when mixed IPL groups will work on both practice-focused and learning-focused solutions to a shared task related to the main topic. A second IPL event a few months later, will be prepared by the members of each group; the direction of the project will be decided by members.

The IPL project strategy:

1) focus groups identify problems, issues & opportunities in IPP

2) a questionnaire based on a case study, completed individually

3) focus group discussion of the case study to identify specific practice and learning / training needs

4) interprofessional focus groups share issues, problems and opportunities raised in initial focus groups, and design strategies (learning programmes?) to resolve / develop these

5) implement strategies

6) evaluate process and outcome, and plan further stages if appropriate.

An action research approach (Hart and Bond, 1995) which allows individual practitioners, carers and users to reflect on current practice and their experience, and engage in a systematic and reflexive process of social inquiry (Winter, 1989), was considered the most appropriate, with a multiple case design (Yin, 1989), and inter-comparison of the groups (Ely & Anzul, 1991). The impact of the project will be evaluated, therefore, in terms of its effect on each participant and by drawing comparisons between the groups, through their attitudes towards IPL and IPP and the extent of their knowledge and understanding of interprofessional collaboration.

The success of the project depends largely on the motivation of the participants and the initial facilitation of the group tasks to establish supportive groups, who feel comfortable in sharing concerns, and problems. If this is achieved group members will be able to challenge their own con-

ceptions as well as those of other professional groups, identify interprofessional barriers and work more effectively toward shared solutions. This stage is essential in order to achieve the ultimate aim to improve services for clients, for it is envisaged that group members may develop their own work - based initiatives.

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Preparing people for inter-professional learning - a personal view

For many years my job has involved the development of interprofessional education in one form or another. Usually this was because the task in hand could be most effectively tackled in this way but often it was a way of preparing people for future work. Good interprofessional learning is one of the most effective, creative and fun activities I know. It produces results quickly, easily and happily. Conversely there is nothing more frustrating than collaborative learning where some of the participants think that they are at a committee meeting. Some participants are expecting trust and mutual enhancement and others are expecting to score points. This misunderstanding destroys enthusiasm and often results in an unhappy mess. Good preparation can avoid this.

Getting it right means that the participants operate in a team mode and different people need different things to help this. Some people have a lot of potential to be team players and they simply need some practice. Others want to operate in a team

mode but tend to consider themselves to be overly central to any work they are engaged in; they may be helped to overcome this by an intensive team development experience (which can be quite confronting and needs a lot of support). Some people have no intention of becoming team players and I communicate with them in their preferred political way.

I have heard arguments for and against different team building approaches. I myself find that a portfolio of approaches is needed. There need to be undramatic, repeatable processes such as team reflection on audit data and effective practice meetings. There need to be intensive self development workshops and residential team building workshops. There need to be policies and disciplinary procedures about things such as contracts and ground rules. All of these are important and must be wisely applied to the situation in hand.

When considering where to use different approaches, it is helpful to remember what is different about interprofessional learning and what it is good at delivering. Inter-professional education does not mean that a number of different professions listen to the same expert. It involves turning to the person next to you and learning from and with them. This changes the power relations in the learning experience. No longer are there teachers and students of different levels of importance. Instead there are co-learners creatively building on each others experiences and insights. Excellence is not measured by how much one can take from another but by how much mutual enhancement is achieved. Interprofessional education is creative and has at its heart the principles of participation, respect and equity. This is what it is good at - (creativity, participation, respect and equity) and the more prepared people are for this the easier it becomes.

I find I can usually gauge the best approach to use by providing the environment where different players can explain to each other their interests and obligations then mix and match these to create a project. I then ask participants (and others) what they think about how to run the project. Usually the best approach becomes obvious. However, it often feels risky and it is easy to make mistakes.

I have used interprofessional educational formats inside organisations such as general practices and health authorities, and between different organisations and practices in localities. I have used them in very small groups and in very large groups. Each of these occasions arose in the context of an emerging opportunity that our team was able to use. We had to gauge whether we were up to the challenge and this involved weighing up time, experience and costs. It also involved training for ourselves. One of the most helpful courses I have ever attended was a City & Guilds Adult Education Course. Here I studied alongside hairdressers, bricklayers and social workers about how people learn. We learned a variety of helpful techniques such as small-group-big-group, goldfish bowl and role play. I have since found that these methods can be usefully applied in general practice but health workers often view even basic things such as brainstorming and ground rules with suspicion. It is early days!

However skilled or confident an individual may feel when embarking on interprofessional learning, they themselves are only going to be as effective as the team in which they are operating. I find it helpful to start anywhere I can and think both long and short term. Is my office a learning environment? In what ways can the meeting I am going to be a more effective learning experience? What person or training or environment would help this to be a more collaborative learning experience? Where is the next generation of facilitators coming from?

The general formula that I now work to includes five 'P's:
• Prepare the ground,
• Plan carefully,
• be Perceptive to opportunities,
• be Patient,
• be Persistent.

It is a fast process - it just seems slow when you live through it.

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Health Care Team Effectiveness

The University of Sheffield together with the Universities of Leeds and Glasgow is undertaking a three year research programme to identify characteristics of healthcare teams which determine effectiveness and individual team member well-being. The study will investigate a range of team structures and processes, including aspects such as professional and demographic mix, communication, collaboration, participation in decision making and objective setting, frequency and style of meetings, interaction and interpersonal processes. Short survey questionnaires to many teams will be followed by an intensive analysis of a sub-sample of teams. Stakeholder workshops will develop effectiveness criteria. A number of outcome measures will be used to assess team effectiveness, including quality of care, patient outcomes (physical and mental health), administrative efficiency (including cost effectiveness) and team member well-being and development.

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Disability and Rehabilitation: Survey of education needs of health and social services professionals

Baker, M., Fardell, J. & Jones, B. (1997) Disability & Rehabilitation Open Learning Project
ISBN 0 9530044 0 6

This reports on a project which sought to ascertain whether and to what extent an educational deficit about disability and rehabilitation existed within professional education and then to provide coordinated input to education with a view to fostering a cooperative multidisciplinary approach to care and services.

The project, carried out between April 1995 and June 1996, consisted of five components:

- focus group work with users and professionals to explore the different meanings of disability;
- in depth interviews with disabled people, their carers and professionals to explore perceptions of the learning needs of professionals;
- a survey of 708 professionals asking them to identify their learning needs and how to best meet them;
- group interviews with multidisciplinary professional groups to explore the precise nature of the educational need;
- a literature search.

The survey found that professionals wanted to develop clinical knowledge and skills, small group interviews identified the need to develop skills in communication, negotiating and coping with emotions. The survey identified a preference for study days, seminars and conferences enabling practitioners to get away from the workplace and gain different perspectives and contacts from networking. Nurses, therapists and social workers welcomed multidisciplinary education, GPs preferred to join with hospital specialists for their continuing education.

Conclusions include:

- There is a clear need for greater collaboration between users, carers and professionals providing care and education within a common philosophical framework.
- Further research is needed to establish a link between poor communication and attitudes and continuing demands on services.
- There is an urgent need for greater collaboration between professional bodies and colleges in developing a coherent, cohesive approach to multidisciplinary education at all levels.

The report recommends:

- creation of a forum to improve care and service provision;
- setting up and supporting a network to disseminate examples of good practice and education;
- fostering the development of a nationally agreed conceptual framework for a coherent, cohesive approach to education and training in disability and rehabilitation;
- providing and evaluating multidisciplinary educational courses and resources;
- holding an annual national multi-agency symposium on disability and rehabilitation.

A management committeee has been set up to take these recommendations forward.

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The benefits of undergraduate interprofessional learning

The Coventry University School of Health and Social Sciences offers a BSc(Hons) in Health Sciences, a multiprofessional postqualifying course. Key aspects of the course are critical analysis and evaluation, joint study and the encouragement of mutual appreciation of professionals. There is also shared learning and teaching at prequalifying level between physiotherapy, occupational therapy, social work and nursing students.

A recent evaluation of the BSc showed that of the students surveyed, 30% were over 41 years old, 20% were aged between 21 and 30 and there were none under 21. The students came from the following professional backgrounds - chiropody, medical laboratory technician, nursing, occupational therapy, orthoptics, physiotherapy and radiography.

The outcomes of the course were considered to be:

aiding personal development - 36%;

increasing professional confidence - 28%;

diversifying career options - 16%;

complementing basic training - 16%;

strengthening clinical experience - 2%.

Graduates reported the benefits as being gaining transferable skills, developing critical appraisal skills which enabled evidence based practice; personal and professional development which changed their practice; developing the confidence, skills and ability to work collaboratively with others and enhancing understanding of organisational structures and processes which improved the way they worked with others to provide care.

Key elements of the course which students valued included:

- a meaningful, focused and common purpose;
- its relevance to contemporary practice and focus on real issues and problems;
- the learning sets in which all students were equally valued;
- the interactive learning process;
- developing appraisal skills and encouraging an evidence based approach to care;
- looking at different theories in depth and the emphasis in the course on bridging the theory/practice gap;
- encouraging students to challenge established practice and fostering innovation;
- the involvement of users and carers.

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Shared Learning, Joint Training or Dual Qualification for Occupational Therapy and Social Work: A report of a feasibility study.

This small scale research project, undertaken by researchers from South Bank University, was funded by CCETSW to explore the feasibility of shared learning, joint training or dual qualification between occupational therapists and social workers in qualifying programmes. The feasibility study was partially inspired by the Social Services Inspectorate report (1993) 'Occupational Therapy: the Community Contribution' which recommended that CCETSW and COT

consider 'ways of developing shared learning within qualifying training to promote better understanding between the social work and occupational therapy professions'.

The aims of the study were:

- to explore and report on the potential for shared learning and interprofessional studies in qualifying programmes;
- to make recommendations regarding the potential for, separate programmes of study with selected structure opportunities for shared learning, shared programmes of study leading to separate qualification and joint programmes leading to dual qualification.

The definitions used are:

Shared learning - stand alone programmes leading to separate qualifications, each with unique structure and regulations, and teaching and learning assesment strategies, but with shared units or modules and some sharing of resources.

Joint training - separate qualifications but validated together, students specify professional route at entry, common structure and regulations, and common teaching and learning strategies with some common assesment. Planned core and profession specific units. Common resources, balanced across the professions.

Dual qualification - common structure and regulations, teaching learning and assesment strategies. Core element predominates but with some profession specific application of selected issues, programme meets requirements of both professional and legal bodies.

These are distinctions between different ways of structuring a qualifying programme. In all teaching and learning may be more or less interprofessional, depending on how far the curriculum focuses on interprofessional issues with an emphasis on interactive methods.

The method chosen was two pronged:
1) An analysis of the curricular requirements of the two professions from the following publications: 'The Rules and Requirements for the Diploma in Social Work' (CCETSW 1995), Curriculun Framework for Occupational Therapy (COT 1993), Code of ethics and professional con-

duct (COT 1995), Statement on the Content of the Occupational Therapy Curriculum (1993) from the World Federation of Occupational Therapists
2) Interviews with senior managers and first line managers in 3 selected authorities in order to explore current working practices and their expectations of newly qualified staff. The interviews targeted three authorities known to be interesed in collaborative work. These included practice managers of services for older people and those with physical disability and also mental health services.

It is acknowledged that these interviews are in no way representative and can only be regarded as a snapshot view in three authorities with an existing interest in joint working.

The methods chosen combine a top down approach based upon the documentation produced by professional bodies, with a bottom up approach that seeks to identify the requirements of current practice. The curriculum comparison has resulted in a chart showing common areas of curriculum, common areas with a different emphasis, parallel areas with a different professional focus and profession specific areas. The final stage of the study is a comparison of this chart with the skills, knowledge and attitudes identified by managers.

The curricular comparison

There are limitations to the documentary comparison due to the different dates and status of the curriculum statements from the two professions. Also, the two professsions use different models of curriculum. However, the comparative chart shows that on paper there are more commonalities than differences in the educational requirements of the two professions. The value base /philosophical underpinning of the two programmes appears to be very similar. The chart identifies areas of skill and knowledge that are common to the two professions, those that are common or parallel but with a different emphasis or focus and those that are specific to each profession. Among common areas are psychology and human development, sociology of the family and interpersonal relations and group dynamics, teamworking and the context of services. Common areas with a different emphasis include trauma loss transi-

tion and change, ethics and values, community care legislation and policy and management and organisations.

There are some possibilities for shared teaching and learning but there remain considerable profession specific areas. For occupational therapy these include anatomy and physiology, medical and psychiatric conditions and functional analysis and methods of improving or maintaining physical and psychological function. Social work requires a more detailed study of legislation and has a greater emphasis on the assesment of risk, abuse and neglect. Any programme leading jointly to professional qualification would need to be a minimum of three years full time.

The expectations of managers in Social Services

For both social workers and occupational therapists, the introduction of care management has led to a shift in professional role. Staff in the three selected authorities were appointed as social workers or occupational therapists but once appointed to physical disability teams, would be expected to carry out a full range of tasks. Managers had similar expectations of all staff on appointement. They saw assesment skills as similar with both professions implementing a model of holistic assesment and sharing a commitment to the values of empowerment and a theoretical understanding of the social model of disablity. In these physical disability teams, both social workers and occupational therapists are working as care managers and drawing on some elements of the knowledge base normally attributed to the other profession. However the position of occupational therapists as care managers is less clear as their skills are predominantly required in specialist assesment. Sometimes a shortage of occupational therapy time has led to social workers taking on some aspects of assessment normally undertaken by occupational therapists. This situation of complementarity and a degree of flexibility in the allocation of tasks led managers to welcome greater shared learning at qualifying level.

Comparison of senior managers expectations with current curricula

Since the implementation of the NHS and Community Care Act, the two professions have been working closely together in the delivery of care to vulnerable adults in the community. At present professional education addresses issues of assessment and care management separately at qualifying level. Shared learning at qualifying level might lead to improved outcomes through the process of studying together interprofessionally as well as enhancing the range of knowledge and skills available to clients.

Senior manager's expectations of staff at the point of qualification include:

- the values held in common by the two professions and the social model of disability;
- the NHS and Community Care Act and the implementation of Community Care;
- contextual knowledge on the structure of the NHS and Social Services.

These could be introduced early in a programme. A module on interprofessional assesment and team working could be introduced later, once a professional foundation had been laid. Opportunities for shared learning could be built into current programmes with relative ease.

The debate around joint training or dual qualification is more complex. A jointly validated programme would require an extension of current curriculum and close cooperation between the professional bodies.

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An Initial Survey of Practice and Service Developments within the Health Care Professions in the United Kingdom.

The implementation of research-based evidence into practice, within the nursing and therapy professions, has long been recognised as an important issue and discussed at length. Despite this however, these professions are still struggling to base practice and/or service developments on evidence.

With this in mind, and in response to the Report of the Taskforce for Nursing, Midwifery and Health Visiting (1993) and the Therapy Colleges' Position Statement (1994), the Practice Service Development Initiative was established in October 1994 within the NHS Centre for Reviews and Dissemination. This Centre promotes the application of research-based evidence in health care relevant to all health care professionals by carrying out or commissioning systematic reviews of the research literature and disseminating the results.

This project was established in order to identify, document and review, practice and service developments currently underway within the NHS and from this to identify people who are active in these developments.

Phase one of the project was to survey professionals regarding practice and service developments with which they were involved. The questionnaire was intended to provide an initial assessment of clinical topic and service areas currently being developed which are funded/non-funded, which are based on research evidence (from the professional`s point of view), which are multidisciplinary whether the development is within primary or secondary care.

During phase two of the project, identified individuals will be linked to each other and existing networks. These flexible links will be made primarily, to provide networks which facilitate the dissemination of research evidence, and secondly, they will help to eliminate duplication and re-invention of the wheel. This initiative contributes to the development of evidence based clinical practice.

A brief questionnaire was mailed to identified health care professionals. A total of 1,485 questionnaires were distributed to health care professional throughout the UK between January and March 1995. Individuals believed to be active in practice and /or service development were specifically targeted. 718 health care professionals returned a completed questionnaire. Ninety four percent of all respondents said that they were currently involved in working toward a practice and/ or service development.

Of these developments

46% state that their developments are explicitly funded

69.5% of respondents stated that their development is research based

60% are involved in multidisciplinary developments

24% of these developments are taking place in primary care alone

49% in secondary care

A further 24% are occurring across both primary and secondary care

The top ten broad clinical topic areas within which respondents are undertaking developments are Community Care, Rehabilitation, Wound Healing, Mental Health, Midwifery health services, Pain, Outpatients, Clinics, Extending professional roles and Cancer.

The next phase of the project involves:

- facilitating contact between health care professionals involved in similar broad topic areas;
- establishing links between these networks and health service research units/groups;
- commissioning and undertaking reviews of research in priority areas;
- disseminating the results of these reviews to relevant networks and researchers, hopefully on disk for distribution regionally.

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Evaluating multidisciplinary education: reflections at half-time

The Scottish Council for Research in Education (SCRE), in collaboration with the School of Nursing and Midwifery and the University of East Anglia, and the Centre for Medical Education at the University of Dundee, is undertaking a two-year project funded by the Department of Health. Our aim is to evaluate the effectiveness of multidisciplinary education for health care professionals.

The first phase of the study comprised a survey of current initiatives in multidisciplinary education. This was not an end in itself. Nor did we wish to replicate the valuable survey work conducted by CAIPE in 1987-8 and 1993-4. Rather, this phase of the research was intended to ensure that the seven matched pairs of case studies, the foci of the second phase of the study, were broadly representative of the state of the art in multidisciplinary education.

The aim of the second phase will be to uncover just how artful that state of the art is. The second phase will comprise in-depth interviews and focus group meetings with course organisers and participants in seven pairs of case studies. These will include provision at both pre- and post- registration level in further and higher education institutions; and practice-based working and learning in primary care and hospital-based settings. The case study pairs will be matched in terms of these criteria, and in respect of background disciplines of the students. We have chosen to locate some examples in the workplace because recent experience has shown that it is difficult to sustain a distinction between learning and working in this field. (Wilson, V.et al: 1996) And indeed we believe it is counterproductive to do so.

As we approach the half-way mark, we would like to take the opportunity to reflect on the first phase of the study, and to share our reflections on the use of terminology.

As others have demonstrated (Leathard, 1992; Barr and Waterton, 1996), mapping multidisciplinary educational initiatives for health care professionals is not easy. As Storrie

(1992) points out, tracking down [opportunities for shared learning] that span the discipline or occupational categories is not straightforward. No directory provides a guide to such programmes... Our own experience bears this out. The term database evokes a reliable and objective state of affairs. The reality is rather different. Databases date very quickly.

In order to make the mapping exercise more manageable, we agreed to identify initiatives in multidisciplinary education which met the following criteria: namely, that they:

- involved at least two health care professions
- involved those working in primary care or in hospital-based settings
- were either at pre-or post-registration/under-or postgraduate level
- were of at least 20 days duration
- were accredited or unaccredited
- were geographically dispersed
- had been in existence for a minimum of two years.

The first criterion represents the provisional baseline for 'multiness': more than one. (This baseline is derived from the literature. We shall come back to the differences between multi and inter when we take a closer look at the use of terminology below.) The second two criteria relate to what the CAIPE survey data told us about the pattern of multidisciplinary educational provision that extended over 20 days or more: namely, that it primarily involved those working in both primary care and hospital-based settings; and although the bulk of provision was at the post- registration/postgraduate level, there were some initiatives at pre-registration/undergraduate level. With regard to the fourth criterion, it is important to bear in mind that the survey phase of the research was intended to inform the selection of case studies. We thus had to ensure we only included in the survey initiatives which were of sufficient duration to enable us to conduct the fieldwork.

Clearly any decision as to which professional or occupational groups to include in an investigation of 'inter' learning and working is to some extent arbitrary. It was thus agreed that the field of enquiry be limited to medicine, nursing, midwifery, occupational therapy, physiotherapy and diagnostic radiography.

Although we were primarily interested in the medicine/nursing/PAMS interface, we envisaged that both the survey and the case study phases of the research might include examples of provision which extended beyond these core groups.

Our criteria for inclusion might appear rather too rigorous. We believe, however, that it is important not to exaggerate the extent of provision by including very short initiatives. Our aim is to talk about multi - and interness , not to talk it up. We conclude with some reflections on terminology.

For some writers, the difference between inter and multi is largely a numerical issue. Inter initiatives involve two professions only (Carpenter, 1995). If a course involves more than two groups, it becomes multi. For others, the difference between 'inter' and 'multi' is more than just a numbers game: working towards interness involves moving into new territory altogether. As a member of a focus group we organised to explore the use of terminology put it, 'interdisciplinary - it's like you are crossing into another space'. Another put the following gloss upon the notion of interdisciplinary endeavour: 'it's like a sort of metadiscipline within which there are disciplinary threads that can be allocated to conventional boxes.'

It is clear that the distinction between the two prefixes is in large measure an epistemological one: what distinguishes 'inter' from 'multi' is the development of forms of knowledge which straddle existing professional, occupational, or indeed disciplinary boundaries. Our review of the literature and the focus group discussion would suggest that the salient characteristics of inter- and multi- initiatives respectively can be summarised as follows. Inter initiatives enable participants to:

- reflect critically on their knowledge base
- engage in shared reflection on practice
- surrender some aspects of their professional role
- share knowledge
- develop a common level of understanding
- find shared values

- develop new interprofessional perceptions
- integrate procedures on behalf of clients
- learn from and about each other.

In contrast, multi -initiatives would appear to:

- develop participants understanding of their role in team
- stem from an increased emphasis on the clients needs
- bring various groups together to understand a particular problem or experience
- focus on the complementarity of procedures and perspectives
- provide opportunities to learn about each other.

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Assessment of Need for Health Visiting

*A research report by **Orla Carney, Jean McIntosh, Allison Worth** and **Jean Lugton**, Glasgow Caledonian University*

The study aimed to explore current methods of assessment of need for health visiting services in order to inform service purchasers and providers of suitable approaches to the current policy requirements for population based needs assessment. The main objectives were:

- to explore the nature and extent of need which health visitors identify
- to elicit health visitors' perceptions of systems of need identification
- to examine the use of a screening instrument in order to estimate the level of unmet need for health visiting intervention.

The study was conducted with two groups of health visitors working in contrasting areas of a major city in the west of Scotland. Methods of research included a referral monitoring study, a case finding survey and interviews.

The main findings were as follows:

- Need as identified by health visitors is complex.
- It is the needs of the individuals with which health visiting is concerned.
- The range of clients seen and needs addressed is extensiv.e
- A case finding approach to the assessment of individual need is of limited value for health visitors.
- Misunderstandings exist between health visitor and social work understanding of their respective roles.
- Health visitors face considerable daily pressure which hinders their ability to work effectively.

*For further information about the purchase of the full report please send an s.a.e to **Maureen Barnes**, Department of Nursing and Community Health, Glasgow Caledonian University, City Campus, Cowcaddens Road, Glasgow G4 0BA*

Social Workers Attached to Practices

This report (August 1996) evaluates a pilot project which involved the attachment of named social workers to GP practices within the Huyton locality in Knowsley from September 1995 to February 1996.

The project demonstrated locally a significant number of benefits of increased collaboration between social services and primary health care practitioners. These benefits were similar to those identified in related projects elsewhere, as were some of the barriers to collaboration and factors effective in overcoming them.

Three key findings seem not to have been emphasised in other similar collaborative work: a flexible approach to social work attachments based on agreements with primary health care teams; a focus at practitioner level on the benefits of district nursing and social work links; clarification that in practice "joint work" should mean routine communication about referral with joint assessment activity is triggered through the use of an agreed protocol.

There were clear improvements in communication in terms of both a mutual understanding of respective roles, responsibilities and constraints, and communication about individual service users.

The pilot demonstrates the value of project planning involving key practitioners and managers which ensures the structured development of this kind of work.

Flexibility was a key factor in both setting up and implementing the attachments. The degree of integration was limited by the existing organisation of the practice but a flexible approach ensured that limited co-ordinated activity was still possible with minimal integration.

A closer working relationship between attached social workers and district nurses is essential and should be co-terminous wherever possible. Co-ordinated work between social services and primary health care staff requires clear agreement for routinely communicating referrals, feedback and progress, which would operate whether or not joint activity took place, and protocols for triggering appropriate joint activity (thereby avoiding unnecessary duplication).

"Ring-fenced" case loads were seen to be easy to assimilate into existing workload management simply because most service users have a GP anyway and therefore, in effect, the same cases are being allocated on a different basis. The project had little impact on the overall referral rate. Social workers' job satisfaction improved overall but this varied in line with the degree of integration and this has clear implications for the allocation of attachments.

A multi-disciplinary steering Group should be maintained to co-ordinate and monitor the further development of this work.

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Collaboration in Health and Welfare

by **A. Loxley** (1997) **Jessica Kingsley**
ISBN 1 85302 394 9 £14.95

Aiming to be an exploration and critical analysis of the concept of collaboration to inform action, this book is written by a founder member of CAIPE, who argues that collaboration can and should be a taught and resourced part of each profession's culture, organisation and repertoire of skills.

It is refreshing to read a book on collaboration wholly written by one person, as most other books on this theme are edited collections with chapters by different authors. This enables a longer, more thorough reflection on the topic.

The opening discussion on public policy and the context of collaboration is a helpful summation of the wide range of influences on collaboration and the tensions in policies that surround it. The discussion of rationales behind the push for collaboration ranges wide - covering ideas about models of health, division of labour, values and relevant social theories.

The difficulties and dangers of collaboration, such as power, the role of the state and culture are outlined, leading to the conclusion that they must be recognised and worked with; that collaboration is not a panacea and must be purposive and applied appropriately.

The tools for achieving collaboration that have been promoted over the years are considered and there is an interesting summary of the historical development of organisations concerned with collaboration. It makes one realise how much talk there has been about it over the years! The book raises many ideas and concludes with a plea for the development of a coherent conceptual framework.

Interprofessional Working for Health and Social Care

by **Ovretveit J.**, **Mathias P.** & **Thompson T.** eds. (1997) Macmillan
ISBN 0 333 64553 7 £13.50

This book is an edited collection with chapters by several different authors. The key messages which shine through are that involving users is essential, that structures make interprofessional working very difficult, that learning together can help and that considerable effort is needed to make interprofessional collaboration a reality. While these are not new messages for readers of this Bulletin, they are well put. In my view the book does succeed in its aim - it does provide a helpful and practicable foundation for practitioners to consider how to improve collaboration with others.

Almost half the book is by Ovretveit, giving a thoughtful and clear outline of the approaches and arrangements encompassed within interprofessional work. The diagrams require some concentrated attention but his chapters certainly help develop a more sophisticated understanding of interprofessional working and include helpful checklists for facilitating collaboration. This is followed by a case example on evaluating interprofessional working in a community mental health team, providing concrete information which could be adapted for use by others elsewhere. His next chapter offers an interesting and ground breaking discussion of how user power affects interprofessional working. While, as he also acknowledges, his proposition that greater equality between users and practitioners means more equality between practitioners needs testing, it does confirm that the concept of interprofessional collaboration must be reshaped to ensure it embraces partnership with users and other members of the community.

The next four chapters on preparing practitioners for interprofessional work, are more descriptive and focus on the recent vocational, modular and standards driven trends in education and the potential they offer for interprofessional learning. The diffi-

culties of interprofessional education are acknowledged, and Weinstein's chapter, drawing on the Joint Practice Teaching Initiative as a case example, offers ideas for overcoming some of them.

The final section, in its consideration of the future of interprofessional working, explores current influences rather than offering visionary ideas. The description of roles as outlined in the functional map of health and social care is detailed, and I would have liked some discussion of how it could be used to deal with the complex issues of roles and traditions that complicate interprofessional work. The chapter by Biggs on the problems and prospects of collaboration concludes with the proposition that user involvement is the best way to prevent interprofessionalism becoming an inward looking and defensive reaction to change and ensure it is positively received rather than feared by practitioners. Thompson and Mathias list 38 health targets of Health for All and argue that they as well as other European policies can be useful drivers for collaboration.

The book ends rather abruptly on this note and would have been enhanced by a synthesis of the ideas and some pointers for the future in a concluding chapter.

Integrated Interdisciplinary Learning between the Health and Social Care Professions

by **Tope R.** (1996) Avebury
ISBN 1 85972 357 8 £49.50

In its 600 odd pages, this book, based on a PhD study and written by a member of CAIPE's Council, provides a rich and thorough range of detailed information about interprofessional education - and would certainly provide much essential information for any university embarking on undergraduate interprofessional education.

The summary of developments and discussion on terminology provide a clear background and rationale for the aims of the study. The literature review

includes an amazingly large number of references from many countries which are succinctly summarised. Leninger's interdisciplinary cone model is summarised and is a very useful framework for developing integrated interprofessional education.

The discussion on the research design is convincing and very well referenced, but it also includes an excellent discussion of many research issues.

The research involved asking professional and statutory bodies about interprofessional education and the listing of their responses (nearly all dated 1992) one after another makes fascinating reading and serves as a useful benchmark to check progress against in future years! The research also involved surveys and interviews with students and teachers, workshops and visits to other countries.

The tables of the content analysis by topics and themes of the reading lists and curricula of fourteen professions are included and provide a valuable foundation for exploring options for common learning. The survey results are all included. Much encouragement can be gained from the high level of support expressed for interprofessional education and much can be learned from the discussion of the details of what the 1383 students and 300 teachers thought could be usefully learned together, when and how.

The recommendations for integrating interdisciplinary learning throughout professional education, that all institutions contemplating introducing interdisciplinary education should join CAIPE, for training the trainers and evaluating initiatives are obviously dear to CAIPE's heart and certainly ones we would support.

Nursing in Primary Health Care

by **Ross F.** & **Mackenzie A.** (1996) Routledge ISBN 0 415 10616 8 £9.99

This book explores important current issues in primary and community care from the nursing perspective. And yes, interprofessional work is given a chapter - perhaps not surprisingly, as one of the authors is a former member of CAIPE's Council. The discus-

sion of terminology and concepts is helpful. The chapter encourages a focus on tasks and patient outcomes rather than the process and nature of collaboration and recognises the obstacle posed by structural barriers and societal forces to interprofessional education and practice. Examples of interprofessional practice are included. Other chapters cover issues of policy, health needs profiling, assessment of individuals' needs, quality of care, carers and new nursing roles in a thoughtful way. They are well referenced with quite a few practice examples and contain much that will be useful to a wider audience than nurses.

A Primary Care-Led NHS

by **Meads G.** (1996) Churchill Livingstone ISBN 0 443 05570 X £21.50

As the final chapter in this book notes, a primary care led NHS means local solutions to local problems and the mix of innovative practice led developments, local variation and lack of overall cohesion, resulting from such an approach is reflected in this book. With 23 chapters each by a different author sketching out the initiative that reflects their vision and identifying the transferable good practice for responding to the opportunities and obstacles from their activities, this book is full of ideas and variety and provides a stimulating read. There are helpful tables, bullets and checklists on pointers which together with jargon free language and a practicable approach help ensure a useful format. Caring organisations, the importance of process, collaborative working, seamless services and partnership are just some of the recurrent themes in this book about an evolving context in which interprofessional education is increasingly essential.

Research Methods in Primary Care

by **Carter Y.** & **Thomas C.** eds. (1997) Radcliffe Medical Press ISBN 1 85775 198 1 £18.50

In his foreword, our own Chairman, Michael Drury, points out that the provision of reliable data about the

effectiveness of interventions in primary care is urgently needed. This book is essentially a "primer", aimed mainly at students but also at practitioners just starting out on research - and for them it provides an excellent introduction to the issues and methods. Each chapter is by a different author and most focus on practical techniques. The majority of contributors are from the Department of General Practice at the University of Birmingham. Apart from one chapter on the role of the nurse in primary care research, the book is rather focused on General Practitioners. Despite this, the points made and information given are widely applicable, with concrete help on how to identify a research question and get started, writing a research proposal, quantitative and qualitiative emthods, data collection and analysis, questionnaire design, systematic reviews, literature appraisal and online research. The style is clear and there are useful case examples. All in all, a user friendly and useful resource.

Outcomes of Community Care for Users and Carers

by **Nocon A.** & **Qureshi H.** (1996) Open University Press ISBN 0 335 19668 3 £14.99

This book opens with a clear discussion of outcomes for service users, dealing head on and succinctly, though, necessarily inconclusively, with such issues as proving attribution, values, links with quality assurance, service process and performance measurement. The limitations of satisfaction surveys are discussed and the need to relate approaches to service objectives is stressed.

An interesting chapter on concepts of user involvement and a resume of the various reports about users' views of community care services completes Part 1 and provides a foundation for Part 3 which explores possible approaches and points the way forward.

Part 2 is a helpful outline of some existing measures, mostly those used regularly in the health sector, and a discussion of the strengths and limitations of each.

The conclusion - that there is no off the shelf solution and that more

research and development initiatives are needed - is undoubtedly realistic, though disappointing if, like me, you were hoping for a readymade approach and guidance on what to do and how. The discussion does give some helpful indicators of some of the considerations in going forward, and the book certainly does fulfill its aim of clarifying and exploring some of the conceptual and methodological issues involved.

Child Protection in Practice

by **PRG Associates**
(telephone 0117-975 4688)

Produced for Camden and Islington Area Child Protection Committees, Local Medical Committee and Health Authority, this resource guide sets out to inform general practice teams about recognsing and responding to child abuse. With clear and not overly detailed information, useful explanations of terminology, legislation and systems, resource contacts, a regular "stocktake" form to reflect on the information given, an emphasis on interagency and interdisciplinary work and an outline referral record sheet, and a well laid out format, it provides an invaluable resource - and an excellent template that would need just minor modifications for other localities.

A Development Pack for Joint Commissioning

by **Paul Gorman**, published by Department of Health 1996

The main focus of this pack is on developing the individuals and teams who are jointly commissioning social care, and it therefore centres on the agencies involved and the formal settings in which they meet. This pack aims to improve their effectiveness by: clarifying roles, responsibilities and boundaries; managing problems more effectively; moving joint commissioning from the margins into the mainstream and generally developing individual and collective understandings of joint commissioning.

The author recognises that joint commissioning has to grow in three areas,

in the services as experienced by users and carers, in the organisations that commission and deliver those services and with the individuals working in joint commissioning.

Organised in two parts, 'Context and Issues' (techniques, process issues that may emerge and key issues in customising the material) and 'Techniques and Other Sources of Help' (practical techniques and exercises used to develop joint commissioning locally). This pack can be used to form the basis of a formal training programme, for facilitating a personal development plan, or perhaps be used as a focus on specific issues in a normal operational or planning meeting. Whatever the usage, the importance of teams and team working in the development of joint commissioning is greatly emphasised, along with vision, leadership and enterprise.

With an easy to follow layout, amusing illustrations and clear exercise plans, which indicate the amount of time each will take, this pack is an extremely useful resource.

Carey McIlvenny
(Available from Two Ten, Building 150, Thorpe Arch Trading Estate, Wetherby, West Yorkshire LS23 7EH)

The Primary Care Workforce: A Descriptive Analysis

by **T. Mathie** (1996) the Royal College of General Practitioners

Although addressing major issues concerning the recruitment and retention of general practitioners, this paper takes a broad view and describes the current trends and issues regarding the present state and future planning of the whole primary care workforce. Briefly and succinctly with useful details of numbers and references, it looks at issues relating to each stage of the general practitioner's training and career patterns and numbers for general practitioners, practice nurses and other practice staff.

It notes inadequacies in current selection and training and a downturn in recruitment and morale in general practice, and points out that the

nature of general practice is changing and that this has led to a change of roles with the non-medical members of the team taking increasing responsibility for some elements. Nurses in primary care appear keen to take on a wider role provided there is appropriate training. It suggests that the increase in size of the primary care workforce and the tendency for larger practice partnerships has benefitted patients but has led to major problems with internal communications.

As it is considered unlikely that there will be a significant increase in resources for health, it suggests improvements will depend on altered working patterns, improved skill mix and efficient use of resources.

Recommendations include:
- extend the influence of primary care in decision making at all levels of the NHS;
- press for an integrated workforce planning forum at national level which should take into account the whole workforce including non-medical staff;
- make multiprofessional training at all levels the norm;
- assist practice nurse colleagues to achieve improvements in training, recognition and professional status;
- RCGP Faculties should review, and if possible increase, the number and scope of multiprofessional events they organise.

1997 _____

10 June

Coordinated Mental Health Care in the Community - Multi-agency Collaboration

Conference in Stafford
Contact Foundation of Nursing Studies, 130 Buckingham Palace Road, London SW1W 9SA

12 June

Interdisciplinary conference at the Tavistock Centre, London:

Implacable Hostility

Contact National Council for Family Proceedings phone 0117-973 1462

1 July

Clarifying Practice through Reflection

in Lyndhurst Contact Sam Williams, IHCS, Bournemouth University, Royal London House, Christchurch Road, Bournemouth BH1 3LT

2 July

Improving Health Care - Listening to children and young people

in London Contact National Children's Bureau, 8 Wakley Street, London EC1V 7QE

9 July

Statistics on Families: their interpretation and meaning

Afternoon seminar in London
Contact National Council for Family Proceedings phone 0117 973 1462

16 - 19 July

"All Together Better Health"

international, interprofessional conference in London.
Contact Profile Productions, Northumberland House, 11 The Pavement, Popes Lane, London W5 4NG ph 0181-566 1902

30-31 August

EMPE (European Multiprofessional Education Network) Conference

in Vienna. Contact Dawn Forman, Institute of Health and Community Studies, University of Derby, Western Road, Mickelover, Derby

10 September

Cleveland Revisited

Conference in London chaired by Rt Hon Lady Justice Butler-Sloss on how interdisciplinary communication and cooperation have changed over ten years

Contact National Council for Family Proceedings phone 0117 973 1462

11-13 September

Changing to Problem Based Learning

an international conference in London

Contact Gaynor Sadlo, Brunel University, Borough Road, Isleworth, Middx TW7 5DU

18-19 September

Quality in Primary Care

Symposium in London.
Contact Conference Unit, RCGP, 14 Princes Gate, London SW7 1PU

19-21 September

Elder Power in the 21st Century

British Society of Gerontology annual conference in Bristol.
Contact Robin Means, School for Policy Studies, Rodney Lodge, Grange Road, Bristol BS8 4EA.

11 November

Towards evaluating practice based interprofessional education and collaborative projects

at the Primary Care Education Centre in West Ealing.
Contact the PCEC, West Ealing House, 2 St James Avenue, London W13 9DP Phone 0181-893 0730.

18 November

Primary Care Protecting Children

major national conference in Leeds by NSPCC. Contact Hazel Sedgwick ph 0113-244 0011

27 and 28 November

Interprofessional Education: Does It Work?

Conference in Liverpool.

Contact Margaret Boaden, Dept of Healthcare Education, University of Liverpool, 3rd floor, University Clinical Department, Duncan Building, Liverpool L69 3GA phone 0151-706 4293.

Forthcoming CAIPE Meetings

23 June Planning Meeting on Working with Education Consortia in North and South Thames from 1.30 to 4pm in London

7 October Trent Meeting from 1.30 to 3.30pm in Rotherham

14 October Regional Meeting in Oxford from 12 to 2pm

15 October Interprofessional Education: The Way Forward in Wales. Consultation meeting in Cardiff

16 October Interprofessional Education Research Support Group in London

28th October Anglia Meeting from 12.30 to 2.30pm in Ipswich

Early 1998 a meeting and workshop on interprofessional education in **Northern Ireland**

Early 1998 a workshop on interprofessional education in **Scotland**